National Practitioner Data Bank

2002 Annual Report

U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions
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Requests for copies of this report and information on the National Practitioner Data Bank should be directed to the Data Bank Customer Service Center, 1-800-767-6732. This report and other information are also available on the Internet World Wide Web at http://www.npdb-hipdb.com.

NATIONAL PRACTITIONER DATA BANK

2002 ANNUAL REPORT

Contents

LIST OF FIGURES

A Snapshot of the NPDB for 2002

In 2002, the majority of reports for the National Practitioner Data Bank (NPDB) were for Medical Malpractice Payments and physicians. Most reports for adverse actions were for State licensure actions. Adverse actions include: licensure actions, clinical privileges actions (actions which adversely affect a practitioner's privileges for more than 30 days), exclusion actions, professional society membership disciplinary actions, actions taken by the DEA concerning authorization to prescribe controlled substances, and revisions to such actions. All of these must be reported to the NPDB if they are taken against physicians and dentists. Since 1997, the NPDB has received Medicare/Medicaid exclusions taken against health care practitioners.

About seven out of ten reports (69.7 percent) are original, initial reports submitted by reporters. Corrected reports, which have been changed by entities to fix errors, account for 17.6 percent of reports. Revision to action reports, which are reports concerning additional actions taken in relation to initially reported actions, account for 12.7 percent of reports. Revision to action reports may concern "non-adverse actions" such as reinstatements and reversals of previous actions.

Queries also increased after a small decrease last year, and 13.5 percent of queries showed the practitioner had a reported medical malpractice payment or adverse action.

These facts and others are explained in the following snapshot of the NPDB for 2002. This snapshot gives the most important details about the contents of the NPDB, which has maintained records of licensure, clinical privileges, professional society membership, and Drug Enforcement Agency (DEA) actions taken against health care practitioners and malpractice payments made for their benefit since September 1, 1990. Since 1997 the NPDB also has included reports of exclusions from participation in the Medicare and Medicaid programs. Operational since September 1, 1990, the NPDB at the end of 2002 contained reports on 318,267 adverse actions and malpractice payments involving 192,451 individual practitioners. Below in more detail is further significant facts about the NPDB in 2002 and cumulatively.

Most 2002 reports were Medical Malpractice Payment Reports, most of them for physicians: During 2002, 70.4 percent of all new reports received concerned malpractice payments; cumulatively, they comprised 72.7 percent of all reports. During 2002, physicians were responsible for 80.6 percent of these reports, dentists 11.0 percent, and all other health care practitioners 8.4 percent. These figures resemble percentages from previous years.

Adverse Action Reports[1] most for State licensure actions, increased in 2002, reversing last year's decline: The 7,989 Adverse Action Reports (licensure, clinical privileges,

[1] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

professional society membership, exclusions, and DEA actions) received during 2002 are 10.8 percent more than the number of Adverse Action Reports received by the NPDB during 2001. This increase comes after a major decrease of 57.9 percent in 2001. The large increase in the number of Exclusion Reports for 2000 shown in Table 2 reflected reports for non-healthcare practitioners and nurse practitioners being submitted to the NPDB for 2000 and previous years. Exclusion Reports for non-healthcare practitioners are being removed from the NPDB. The number of licensure action reports received increased 29.7 percent from 2001 to 2002. During 2002, licensure action reports comprised 51.5 percent of all Adverse Action Reports and clinical privilege action reports comprised 12.4 percent. Adverse actions represent 27.3 percent of all reports received cumulatively and 29.6 percent (7,989 of 26,988) of all reports received by the NPDB during 2002.

Entity requests for information from the NPDB ("queries") increased slightly in 2002, helping put total cumulative queries over 28 million: Over its existence the NPDB responded to over 28.7 million inquiries ("queries") from authorized organizations such as hospitals and managed care organizations (HMOs, PPOs, etc.), State licensing boards, professional societies, and individual practitioners seeking to review their own records. Entity query volume from 2001 to 2002 increased 0.7 percent, from 3,230,543 queries in 2001 to 3,253,805 queries in 2002. This increase followed the decrease in queries from 2000 to 2001, the first decrease in queries since the opening of the NPDB.

Most queries are voluntary and not required by law, and over half of voluntary queries come from Managed Care Organizations (MCOs): Hospitals are required by law to query. All other queries are voluntary. During 2002, 65.6 percent of queries were submitted by voluntary queriers; cumulatively well over half (59.1 percent) of the queries were voluntary. Of the voluntary queriers, MCOs are the most active, making 50.0 percent of all queries during 2002. Although they represent only 19.1 percent of all entities that have ever queried the NPDB, they had made 45.4 percent of all queries cumulatively. The number of mandatory hospital and voluntary queries both increased by about 3.3 percent from 1998 to 2002. However, over the NPDB's existence the increase in voluntary queries has been much larger than the increase in mandatory hospital queries.

More than one out of eight queries show the practitioner has a reported medical malpractice payment or adverse action: When a query is submitted concerning a practitioner who has one or more reports, a "match" is made, and the querier is sent copies of the reports. During 2002, 13.5 percent of all entity queries resulted in a match (439,761 matches). Cumulatively, the match rate is 11.0 percent (3,154,393 matches). No match on a query means a practitioner has no reports in the NPDB. Since the NPDB has been collecting reports since 1990, a non-match response indicating that a practitioner has no reported payments or actions is valuable to queriers.

Physicians, most of whom only have one report, are predominant in the NPDB: Of the 192,451 practitioners reported to the NPDB, 69.1 percent were physicians (including M.D. and D.O. residents and interns), 13.7 percent were dentists, 7.5 percent were nurses and nursing-related practitioners, and 2.9 percent were chiropractors. About two-thirds of physicians with reports (64.4 percent) had only one report in the NPDB, 84.3 percent had two or fewer

reports, 97.2 percent had five or fewer, and 99.6 percent had 10 or fewer. Few physicians had both Medical Malpractice Payment Reports and Adverse Action Reports. Only 6.7 percent had at least one report of both types (excluding Medicare/Medicaid Exclusion Reports).

Physicians have more reports per practitioner than any other practitioner group: Physicians have the highest average number (1.77) of reports per reported physician, and dentists, the second largest group of practitioners reported, have an average of 1.62 reports per reported dentist. Podiatrists and podiatric-related practitioners, who have 1.72 reports per reported practitioner, also have a high average of reports per practitioner as well as more than 5,000 total reports. Comparison between physicians and dentists and other types of practitioners, however, would be misleading since reporting of licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

Physicians have more than three-quarters of the malpractice payments in the NPDB: Physicians had 78.3 percent of the Malpractice Payment Reports cumulatively in the NPDB (181,073 reports), and they had 80.6 percent of payment reports in 2002 (15,304 reports). Physician Malpractice Payment Reports decreased 8.2 percent from 2001 to 2002. Dentists had 13.6 percent of Malpractice Payment Reports cumulatively in the NPDB (31,476 reports), and they had 11.0 percent of payment reports in 2002 (2,087 reports). Other practitioners had 8.1 percent of payment reports cumulatively (18,690 reports) and 8.4 percent of payment reports for 2002 (1,586 reports).

Average medical malpractice payment amounts for physicians in 2002 were higher than in previous years: The median and mean medical malpractice payment amounts for physicians in 2002 were $150,000 and $275,094, respectively. Cumulatively since 1990 for physicians the median amount was $100,000 ($112,374 adjusting for inflation to standardize payments made in prior years to 2002 dollars) and the mean amount was $214,333 (approximately $242,559 adjusting for inflation).[2]

Obstetrics-related medical malpractice payments for physicians continued to be higher than others, while miscellaneous and equipment/product-related payments were lower: During 2002, as in previous years, obstetrics-related cases, generating 7.4 percent of all 2002 physician Malpractice Payment Reports, had the highest median payment amounts ($265,000). This median payment was $15,000 more than in 2001. Miscellaneous incidents (1.1 percent of all reports) had the lowest median payments during 2002 ($30,500).

Mean delay between an incident and its malpractice payment decreased by more than a month: For 2002 medical malpractice payments, the mean delay between an incident that led to a payment and the payment itself was 4.35 years. This signifies a decrease of 40 days from 2001. The 2002 mean physician payment delay varied markedly between the States, as in previous years, and ranged from 2.75 years in North Dakota to 6.42 years in Rhode Island.

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[2]Generally for malpractice payment data the median is a better indicator of the "average" or typical payment than is the mean since the mean is skewed by a few very large payments.

Most hospitals registered with the NPDB have not reported a clinical privileges action: Of those hospitals currently in "active" registered status with the NPDB, 54.3 percent of the hospitals have never submitted a clinical privilege report. This percentage has steadily decreased over the years. Additionally, over the history of the NPDB, there are nearly four times more licensure reports than clinical privilege reports. Clinical privilege reporting seems to be concentrated in a few facilities even in States with comparatively high overall hospital clinical privileging reporting levels. The Health Resources and Services Administration (HRSA) continues its efforts to investigate the low level of clinical privilege reporting.

Most reports are not disputed by practitioners: A practitioner about whom a report has been filed may dispute either the accuracy of the report or the fact that the report should have been filed. At the end of 2002, 4.3 percent (1,909) of all licensure reports, 14.4 percent (1,657) of all clinical privilege reports, and 3.7 percent (8,584) of all Malpractice Payment Reports in the NPDB were in dispute.

Few practitioners request Secretarial Reviews, most of which are for adverse actions: If the disagreement (dispute) is not resolved between the practitioner and the reporter, the practitioner may ultimately request a review of the report by the Secretary of Health and Human Services. Only a few practitioners who dispute reports also request Secretarial Review; there were 119 requests out of 12,449 disputed reports for Secretarial Review during 2002. Adverse actions comprise 70.3 percent of all 2002 requests for Secretarial Review and 62.0 percent of all requests cumulatively for Secretarial Review. This is in sharp contrast to the 29.6 percent of all reports represented by adverse actions in 2002 and the 27.3 percent of all Adverse Action Reports cumulatively.

Most Secretarial Review requests result in the report staying in the NPDB: Cumulatively, only 15.0 percent, or 237 out of 1,584 cumulative requests for Secretarial Review have resulted in positive outcomes for practitioners (which include the request being closed by an intervening action such as submission of a corrected report by the reporting entity, the Secretary changing the report, and the Secretary voiding the report). Of the 119 requests for Secretarial Review received in 2002, 56 cases were resolved this year. Of these resolved requests, 7 were closed by intervening action (such as submission of a corrected report by the reporting entity), 3 were voided, and one was closed because the practitioner did not pursue review. The rest were unchanged and maintained as submitted.

The NPDB's Policies, Operations, and Improvements

The NPDB Program: Protecting the Public

The National Practitioner Data Bank (NPDB) has an important mission established by law – protecting the public by restricting the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previously damaging or incompetent performance. The following explains how this mission is accomplished and the rules and regulations under which the NPDB operates.

The NPDB and its mission were established by a law that also encourages the use of peer review: The National Practitioner Data Bank (NPDB) was established to implement the *Health Care Quality Improvement Act of 1986, Title IV of P.L. 99-660*, as amended (the HCQIA). Enacted November 14, 1986, the Act authorized the Secretary of Health and Human Services to establish a national data bank, the NPDB.

The HCQIA also includes provisions encouraging the use of peer review. Peer review bodies and their members are granted immunity from private damages if their review actions are conducted in good faith and in accordance with established standards. However, entities found not to be in compliance with NPDB reporting requirements may lose immunity for three years.

A division of the Federal government administers the NPDB and a contractor operates it, with input from an outside committee: The Division of Practitioner Data Banks (DPDB) of the Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS), is responsible for administering and managing the NPDB program. The NPDB itself is operated by a contractor, SRA International, Inc. (SRA), which began doing so in June 1995.[3] SRA created the Integrated Querying and Reporting Service (IQRS), an Internet reporting and querying system for the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB).[4]

An Executive Committee provides health care expertise for SRA on operations and policy matters. The committee includes approximately 30 representatives from various health professions, national health organizations, State professional licensing bodies, malpractice insurers, and the public. It usually meets two times a year with both SRA and DPDB personnel.

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[3]SRA replaced Unisys Corporation, which had operated the NPDB from its opening on September 1, 1990.

[4]A separate annual report for just the HIPDB is also prepared by DPDB and is available on the Data Banks' Web site at www.npdb-hipdb.com.

The NPDB receives information about five different types of actions taken against practitioners: The NPDB is a central repository of information about: (1) malpractice payments made for the benefit of physicians, dentists, and other health care practitioners; (2) licensure actions taken by State medical boards and State boards of dentistry against physicians and dentists; (3) professional review actions primarily taken against physicians and dentists by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies; (4) actions taken by the Drug Enforcement Administration (DEA), and (5) Medicare/Medicaid exclusions.[5] Information is collected from private and government entities, including the Armed Forces, located in the 50 States and all other areas under U.S. jurisdiction.[6]

The NPDB's information is accessible to certain health care entities and licensing boards for specific reasons: NPDB information is made available upon request to registered entities eligible to query (State licensing boards, professional societies, and other health care entities that conduct peer review, including HMOs, PPOs, group practices, etc.) or required to query (hospitals). These entities query about practitioners who currently have or are requesting licensure, clinical privileges, affiliation, or professional society membership.

The NPDB's information only alerts health care organizations receiving it that they may want to look closer at a practitioner's record: The NPDB's information alerts querying entities of possible problems in a practitioner's past so they may further review a practitioner's background as needed. The NPDB augments and verifies, not replaces, other sources of information. It is a flagging system only, not a system designed to collect and disclose full records of reported incidents or actions. It also is important to note the NPDB does not have information on adverse actions taken or malpractice payments made before September 1, 1990, the date it opened. As reports accumulate over time, the NPDB's information becomes more extensive, and therefore more valuable.

NPDB information helps health care organizations make good licensing and credentialing decisions: Although the Act does not allow release of practitioner-specific NPDB information to the public, the public does benefit from it. Licensing authorities and peer reviewers get information needed to identify possibly incompetent or unprofessional physicians, dentists, and other health care practitioners. They can use this information to make better licensing and credentialing decisions that protect the public.

The NPDB research program and public use file helps improve health care through analysis of data: In addition, to help the public better understand medical malpractice and disciplinary issues, the NPDB responds to individual requests for statistical information, conducts research, publishes articles, and presents educational programs. A Public Use File

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[5]Hospitals and other health care entities also may voluntarily report professional review (clinical privileges) actions taken against licensed health care practitioners other than physicians and dentists.

[6]In addition to the 50 States, the District of Columbia, and Armed Forces installations throughout the world, entities eligible to report and query are located in Puerto Rico, the Virgin Islands, American Samoa, the Federated States of Micronesia, Guam, the Northern Mariana Islands, and Palau.

containing selected information from each NPDB report also is available.[7] This file can be used to analyze statistical information. For example, researchers could use the file to compare malpractice payments made for the benefit of physicians to those made for physician assistants in terms of numbers and dollar amounts of payments, and types of incidents leading to payments. Similarly, health care entities could use the file to identify problem areas in the delivery of services so they could target quality improvement actions toward them.

The NPDB receives required reports on "adverse" actions: Adverse Action Reports[8] must be submitted to the NPDB in several circumstances.

- When a State medical board or State board of dentistry takes certain licensure disciplinary actions, such as revocation, suspension, or restriction of a license, for reasons related to a practitioner's professional competence or conduct, a report must be sent to the NPDB. Revisions to previously reported actions also must be reported.

- A clinical privilege report must be filed with the NPDB when (1) a hospital, HMO, or other health care entity takes certain professional review actions that adversely affect for more than 30 days the clinical privileges of a physician or dentist, or when (2) a physician or dentist voluntarily surrenders or restricts his or her clinical privileges while being investigated for possible professional incompetence or improper professional conduct or in return for an entity not conducting an investigation or reportable professional review action. Revisions to previously reported actions also must be reported. Clinical privileges actions also may be reported for health care practitioners other than physicians and dentists, but it is not required.

- When a professional society takes a professional review action based on reasons related to professional competence or professional conduct that adversely affects a physician's or a dentist's membership, that action must be reported. Revisions to previously reported actions also must be reported. Such actions also may be reported for health care practitioners other than physicians or dentists.

- Under the Memorandum of Understanding between the U.S. Department of Health and Human Services and the DEA, the DEA has agreed to report all revocations and voluntary surrenders by practitioners of DEA registration "numbers".

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[7]Information identifying individual practitioners, patients, or reporting entities other than State licensing boards is not released to the public in either the Public Use File or in statistical reports. The Public Use File may be obtained from the NPDB Web site at www.npdb-hipdb.com. A detailed listing of the numbers and values for each variable is also available at www.npdb-hipdb.com.

[8] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

The NPDB receives reports on Medicare/Medicaid Exclusions, which are considered to be adverse actions: The HHS's exclusion of a practitioner from Medicare or Medicaid reimbursement is reported to the NPDB, published in the Federal Register, and posted on the Internet. Placing the information in the NPDB makes it conveniently available to queriers, who do not have to search the Federal Register or the Internet to find out if a practitioner has been excluded from participation in these programs.

The NPDB receives required reports on malpractice payments: Medical Malpractice Payment Reports must be submitted to the NPDB when an entity (but not a practitioner out of his or her personal funds[9]) makes a payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner.

Certain health care entities can request information from the NPDB: Hospitals, certain health care entities, State licensure boards, and professional societies may request information from (query) the NPDB. Hospitals are required to routinely query the NPDB. A hospital also may query at any time during professional review activity. Malpractice insurers cannot query the NPDB.[10]

A hospital must query the NPDB:

- When a physician, dentist, or other health care practitioner applies for medical staff appointments (courtesy or otherwise) or for clinical privileges at the hospital; and

- Every 2 years (biennially) on all physicians, dentists, and other health care practitioners who are on its medical staff (courtesy or otherwise) or who hold clinical privileges at the hospital.

Other eligible entities may request information from the NPDB:

- Boards of medical or dental examiners or other State licensing boards may query at any time.

- Other health care entities, including professional societies, may query when entering an employment or affiliation relationship with a practitioner or in conjunction with professional review activities.

The NPDB also may be queried in two other circumstances:

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[9]Self-insured practitioners originally reported their malpractice payments. However, on August 27, 1993, the U.S. Court of Appeals for the D.C. Circuit reversed the December 12, 1991, Federal District Court ruling in *American Dental Association, et al., v. Donna E. Shalala*, No. 92-5038, and held that self-insured individuals were not "entities" under the HCQIA and did not have to report payments made from personal funds. All such reports have been removed from the NPDB.

[10]Self-insured health care entities may query for peer review but not for "insurance" purposes.

- Physicians, dentists, or other health care practitioners may "self-query" the NPDB about themselves at any time. Practitioners may not query to obtain records of other practitioners.

- A plaintiff or an attorney for a plaintiff in a malpractice action against a hospital may query and receive information from the NPDB about a specific practitioner in limited circumstances. This is possible only when independently obtained evidence submitted to HHS discloses that the hospital did not make a required query to the NPDB on the practitioner. If it is demonstrated the hospital failed to query as required, the attorney or plaintiff will be provided with information the hospital would have received had it queried.

Fees for requests for information (queries) are used to operate the NPDB, which is self-supporting: As mandated by law, user fees, not taxpayer funds, are used to operate the NPDB. The NPDB fee structure is designed to ensure the NPDB is self-supporting. All queriers must pay a fee for each practitioner about whom information is requested. During 2002, the base entity query fee was $5 per name. Self-queries, which are more expensive to process because they require some manual intervention, cost a total of $20 for both the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB)[11]. Self-queries must be submitted to both data banks to ensure that queriers receive complete information on all NPDB-HIPDB reports. All query fees must be paid by credit card at the time of query submission or through prior arrangement using automatic electronic funds transfer.

NPDB information about practitioners is confidential and available to users for only specific reasons: Under the terms of the HCQIA, NPDB information that permits identification of particular practitioners or entities is confidential. The HHS has designated the NPDB as a confidential "System of Records" under the Privacy Act of 1974. Authorized queriers who receive NPDB information must use it solely for the purposes for which it was provided. Any person violating the confidentiality of NPDB information is subject to a civil money penalty of up to $11,000 for each violation.

Criminal penalties punish those who disclose or report information under false pretenses: The Act does not allow the NPDB to disclose information on specific practitioners to medical malpractice insurers or the public. Federal statutes provide criminal penalties, including fines and imprisonment, for individuals who knowingly and willfully query the NPDB under false pretenses or who fraudulently gain access to NPDB information. There are similar criminal penalties for individuals who knowingly and willfully report to the NPDB under false pretenses.

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[11]The Healthcare Integrity and Protection Data Bank (HIPDB) is a flagging system run by the Federal government to flag or identify health care practitioners, providers, and suppliers involved in acts of health care fraud and abuse. The HIPDB includes information on final adverse actions taken against health care practitioners, providers, or suppliers. Information is restricted to Federal and State government agencies and health plans. The NPDB and HIPDB are both operated under the direction of the DPDB, and entities report to and query both data banks through the same Web site at www.npdb-hipdb.com.

Practitioners receive copies of reports and may add personal statements to their reports: Reports to the NPDB are entered exactly as received from reporters. To ensure accuracy, each practitioner reported to the NPDB is notified a report has been made and is provided a copy of it. Since March 1994, the NPDB has allowed practitioners to submit a statement expressing their views of the circumstances surrounding any report concerning them. The practitioner's statement is disclosed along with the report.

Practitioners may dispute or ask for Secretarial Review of their reports: If a practitioner decides to dispute the report's accuracy in addition to or instead of filing a statement, the practitioner is requested to notify the NPDB that the report is being disputed. The report in question is then noted as under dispute when released in response to queries. The practitioner also must attempt to work with the reporting entity to reach agreement on correction or voidance of a disputed report. If a practitioner's concerns are not resolved by the reporting entity, the practitioner may ask the Secretary of Health and Human Services to review the disputed information. The Secretary then makes the final determination whether a report should remain unchanged, be modified, or be voided and removed from the NPDB.

Federal agencies and health care entities participate in the NPDB program under Memoranda of Understanding (MOUs): Section 432(b) of the Act prescribes that the Secretary shall seek to establish a MOU with the Secretary of Defense and with the Secretary of Veterans Affairs to apply provisions of the Act to hospitals, other facilities, and health care providers under their jurisdictions. Section 432(c) prescribes that the Secretary also shall seek to enter into an MOU with the Administrator of the Drug Enforcement Administration, Department of Justice (DEA), concerning the reporting of information on physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under Section 304 of the Controlled Substances Act.

The Secretary signed an MOU with the Department of Defense (DOD) September 21, 1987, with the DEA on November 4, 1988 (revised on June 19, 2002), and with the Department of Veterans Affairs (DVA) November 19, 1990. In addition, MOUs with the U.S. Coast Guard (Department of Transportation) and with the Bureau of Prisons (Department of Justice) were signed June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented November 9, 1989 and October 15, 1990.

Medicare/Medicaid exclusions have been reported under an agreement since 1997: Under an agreement between HRSA, the Centers for Medicare & Medicaid Services (CMS), and the Office of Inspector General (OIG), Medicaid and Medicare exclusions were placed in the NPDB in March 1997 and have been updated periodically. Reinstatement reports were added in October 1997. The initial reports included all exclusions in effect as of the March 1997 submission date to the NPDB regardless of when the penalty was imposed.

The NPDB: Proven Successful in Influencing Licensing and Privileging of Health Care Practitioners

Is the National Practitioner Data Bank (NPDB) meeting its intent? A 2001 study by the Institute for Health Services Research and Policy Studies at Northwestern University and the Health Policy Center Survey Research Lab at the University of Illinois at Chicago shows the NPDB serves its users well and has a positive impact on the healthcare system. More than 1,000 queriers to the NPDB were randomly surveyed to find out more about their experiences with obtaining information from the data bank. Below is information about the NPDB users' responses to the survey.

QUERYING THE NPDB

- **Important –** Healthcare providers said the NPDB information used during the credentialing process is important. On a 1 to 7 scale, with 7 representing "very useful," three-quarters of surveyed queriers rated NPDB information a "6" or a "7." The average score was 6.16.

- **Influential –** Fifty-seven percent of surveyed queriers found the NPDB information they received to be very influential (6 and 7 on a 7 point scale) in decision-making regarding practitioners.

- **Makes a Difference –** Surveyed users said that 9 percent of the time they received a matched query response, their decision to license or credential the practitioner would have been different if they had not received the NPDB information. This means that the NPDB's information changes almost 40,000 credentialing and licensing decisions each year.

- **Needed –** The NPDB also provides useful types of information. Surveyed queriers said that 7 out of 10 sample types of NPDB information were very useful. Information considered to be the most important were revocations and suspensions imposed by State licensing boards, rated 6.86 and 6.78, respectively, on a 1 to 7 scale of importance. These facts show the NPDB provides the data users need.

- **Not Previously Known –** In a small, but significant portion of cases, NPDB reports represent new information. Of the more than 600 queriers who were asked about their match responses to queries, about 15 percent of them said they received new information. Thus, the NPDB helps show a more complete picture of a practitioner's background during the credentialing process.

- **Comprehensive –** Among surveyed queriers who received a match, only about 4 percent found information from other sources that the NPDB reports did not contain. Notably, most of those cases involved information on events that took place before the data bank opened for reporting and querying.

- **Timely –** Entities receive responses to their queries in a timely manner. The majority of respondents said they received a response to their queries in one day or less. A bigger percentage of respondents felt that responses were timelier than those from a sample of entities that were surveyed in 1994.

- **Authoritative –** In only about 3 percent of the time did queriers with matches find information from other sources that contradicted information in NPDB reports. In most cases, when they made follow-up inquiries to resolve the contradiction, they found the NPDB information to be accurate.

- **A Basic Source –** The majority of queriers who found NPDB information to be useful said that NPDB reports serve well as a basic source of credentialing information and confirm other sources of information.

REPORTING TO THE NPDB

Along with asking queriers about their user satisfaction, reporters were also examined in the study by the Northwestern University Institute for Health Services Research and Policy Studies and the University of Illinois at Chicago Health Policy Center. A survey questionnaire of reporters that elicited 643 responses shows that most reporters are satisfied with the NPDB reporting process.

- **Satisfied –** In a range of 1 to 7, with "6" or "7" meaning "very satisfied," surveyed users gave reporting to the NPDB an average satisfaction score of 5. Between 30 to 45 percent of them were "very satisfied" with reporting.

- **Easy –** Assigning action classification codes for reports is not difficult for entities to accomplish. About 30 percent of respondents found assigning adverse action classification to be easy (1 and 2 on a 7 point scale of difficulty) and about 52 percent of respondents found assigning the allegation of negligence codes to be easy.

- **Improving –** Surveyed reporters recommended improvements in software user friendliness and instructions. In response to these recommendations, some changes have recently been made. The NPDB Interactive Training Program at www.npdb-hipdb.com shows reporters the step-by-step process for submitting and changing reports. The Web site was also redesigned, making it easier to use.

The NPDB Improves Its Operations and Policies in 2002

The NPDB cut its user response time in half and increased the information users receive from it in 2002. The National Practitioner Data Bank (NPDB) also continued updating and organizing its Web site, www.npdb-hipdb.com, to make it easier for customers to find information.

In addition, in recognition of its achievements the data banks were awarded a 2002 Electronic Government Trailblazer Award by the Industry Advisory Council's (IAC) eGov Shared Interest Group (SIG), in partnership with E-Gov and the Federal CIO Council. The IAC is an organization of IT professionals representing more than 300 companies nationwide that provide products and services to the government. The award was the result of successfully converting the NPDB-HIPDB to an electronic government system that uses the Internet. This system provides customers rapid system access and response as well as simplified payment through credit cards and electronic funds transfer.

The following improvements were made to the NPDB system in 2002.

- Response time to users decreased from 3 to 4 hours to 1 to 2 hours. This resulted from improved hardware architecture.

- The number of allowable adverse action classification codes and basis of action codes were increased, resulting in more information for users. These codes describe the action taken against a licensed practitioner and the reason these actions were taken. More allowable codes let reporters show more fully the actions that took place and their reasons.

- The entity registration process was improved. Entities can now designate their agents for reporting and querying online and can also authorize Electronic Funds Transfer (EFT) to pay for queries online.

- The capability of providing data bank supplemental information on reports was added. For example, it's now possible to note that the subject of the report is deceased. Also added was the capability of entities to include a reporting point-of-contact on reports.

- A new data bank correspondence system was created. Registered entities and agents can now receive newsletters, upcoming events and changes, and other information directly in their electronic mailboxes.

- A new Report Response Service was created, which allows the report subject to update mailing addresses online and submit and update subject statements online.

The following improvements were made to the NPDB Web site in 2002:

- Updated versions of the Interface Control Documents (ICDs), Authorized Agent List and Public Data Files were added.

- The Quick Lists icons on the home page were modified and reordered, making the Web site easier to use. The categories of the list include "Perform a Self-Query," "Go to the IQRS," "Get NPDB-HIPDB Forms," and "Interactive Training."

- A new fact sheet on importing subject data into the IQRS and a sample import file were added to the Web site.

Along with these improvements, a new Customer Resource Management (CRM) system was implemented in 2002 to improve customer service. It electronically integrates phone calls, e-mail, voice and letter correspondence, creating a single interface or process that records all customer interactions.

Beyond operations improvements, the NPDB had several successful policy-related accomplishments in 2002. For example, the NPDB took major efforts to ensure compliance with reporting requirements. The NPDB staff also attended and presented at several credentialing and health care organization meetings, and developed articles and brochures publicizing the data bank's mission, requirements, and achievements.

The NPDB achieved the following in the policy area:

- State Licensing Boards – A letter was also sent to 15 State medical boards for States where there have been five or more reports made to the NPDB by health care entities regarding privileging, but none of the reports reflects an action taken against the practitioner by the State board. The boards were asked if they had taken an adverse action against the practitioner and were reminded to report such actions to the NPDB.

- Hospitals – Hospitals listed in the "American Hospital Association Guidebook" were checked for registration in the data banks. Unregistered hospitals were contacted and made aware of their requirements to query and report to the data banks.

- Malpractice Payment Reporting – Loopholes for malpractice payment reporting, such as Corporate Shield, Loss Adjustment Expenses, and High-Low Agreements, were investigated to discover methods or regulations for closing them. Insurers, health care lawyers, and other interested parties were asked for their feedback on these matters. Major work was also done to revise the Medical Malpractice Payment Report codes.

- Brochures – A new brochure was developed and distributed to health care organizations – "NPDB – A Success Story." This publication describes the positive results of an NPDB user survey that show the NPDB to be a success.

- Media Search – A system that investigates reports of medical mistakes made by practitioners in the media was created. Each news event is examined to see if a report was made concerning it to the NPDB and/or HIPDB.

- Contacts – NPDB staff presented at or exhibited materials at the conferences of several organizations, as well as discussed data bank issues with representatives of several organizations. These groups included the American Association of Health Plans, Administrators in Medicine, Department of Veterans Affairs, National Council of State Boards of Speech Language Pathologists and Audiologists, American Health Lawyers Association, and the National Association of Medical Staff Services. These contacts greatly promoted the data banks' missions and helped increase compliance with reporting and querying requirements.

- PreP4 Patient Safety – The Practitioner Remediation and Enhancement Partnership Pilot Project is in Phase Two of its program under a new contract with the Citizen Advocacy Center. PreP4 Patient Safety is a pilot project that provides tools for State medical and nursing boards to work with hospitals and other health care organizations to identify, remediate and monitor health care practitioners with deficiencies that do not rise to the level of disciplinary action. This improves patient safety by allowing organizations and licensing boards to work together in a collegial manner to identify providers with clinical deficiencies in a non-punitive environment. The Citizen Advocacy Center will provide technical assistance to State licensing boards and hospitals currently participating in PreP4 Patient Safety, encourage additional State boards to join PreP4 Patient Safety, and promote better compliance with Federal and State mandatory reporting laws.

- Long Term Care Facilities – The new Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for 2003, which require long term care and subacute care facilities to query the NPDB, prompted DPDB to review which long term facilities were registered or queried the data banks. It was discovered that only a small number of facilities that JCAHO accredited were registered with the NPDB. Efforts to increase these organizations' registrations and queries were underway.

- Section 1921 – Data bank staff worked on preparing for the implementation of Section 1921 of the Social Security Act and potential system changes. Section 1921 was enacted to provide protection to program beneficiaries from questionable health care practitioners and to improve anti-fraud provisions of the Medicare, Medicaid, and other State health care programs. Under Section 1921, all adverse licensure actions taken against all health care practitioners must be reported to the NPDB. The data bank will also include any negative action or finding by a Peer Review Organization (PRO), State licensing authority, or private accreditation organization. Additionally, Federal and State agencies, law enforcement, MFCUs, PROs, and other health care entities will be able to query the NPDB, with limitations. Decisions on policy issues, including data bank registration

and/or re-registration and copying/transferring data from HIPDB to NPDB also were considered. Staff also worked on developing a Section 1921 marketing plan.

- Articles – Data bank staff wrote two articles for the newsletter of the Physician Organizations Practice Group of the American Health Lawyers Association. Readership of the newsletter is primarily attorneys who represent physicians and practitioners. One article discussed what lawyers and practitioners needed to know about being reported to the data banks and how to add statements or dispute reports. Another article explained how the NPDB works and cleared up misunderstandings about the data bank. Articles about speech-language pathologists and audiologists and dentists, introducing these practitioners to information contained in the data banks, are being written for publication in newsletters and journals for those professions and their boards.

- Marketing Campaign – Research is being done to plan and implement strategies that promote querying and reporting to the NPDB-HIPDB, with the main focus on querying and non-querying entities. The campaign includes activities such as identifying NPDB-HIPDB queriers, non-queriers, reporters, and non-reporters; profiling entity groups through research; categorizing groups into marketing segments; and developing marketing activities best suited for these segments. DPDB staff is currently working to finalize procedures and schedule activities for marketing campaigns.

- Subject Notification Documents – Reports distributed to queriers will note the practitioner may not have received notice of the report if the practitioner's notice was returned by the postal service.

The following are research and achievements that the NPDB-HIPDB accomplished in 2002. They include activities directed at enhancing the accuracy of data in the NPDB and comparing NPDB-HIPDB reports with those reported to national organizations by State licensing boards.

- Data Reporting Issues – Work continues on improving the accuracy, timeliness, and completeness of data in the NPDB. This includes investigating data that have bad dates (e.g., actions apparently taken later than the date of its report; impossible dates such as 999 or 3099), incomplete information, and late reports. Corrections to the data were made in 2002 with the help of SRA, and selected entities were contacted to encourage them to report in a more timely way. As well as ensuring the quality, accuracy, and timeliness of information provided to health care entities, this project also assures that accurate and reliable data is available for research.

- State Licensing Actions Comparison – An effort is being made to improve completeness and accuracy of State licensure reports by ensuring that reports submitted on physicians to the NPDB-HIPDB are consistent with those reported to the Federation of State Medical Boards (FSMB) by State licensing boards. There is evidence that the NPDB-HIPDB and FSMB do not receive all and/or the same licensure reports they should be, and reporting from State licensing boards is not complete in some cases.

Currently, SRA is comparing all physician licensure actions reported to the FSMB during 2000 to NPDB licensure data for physicians for 2000.

- High Volume Clinical Privileges Reporters (HVCPR) – A research project is ongoing to identify frequent reporters of clinical privileges actions and describe patterns of hospitals that have submitted four or more reports of clinical privileges actions. The project is also meant to analyze the relationship between the number of clinical privilege reports and organizational characteristics (e.g., number of beds, personnel, non-profit/profit/government ownership). This project may help improve data on clinical privileges actions by examining characteristics and best practices that lead to relatively high volumes of reporting. Gaining insight into the behavior of entities that do report clinical privileges might also provide a context for developing educational materials directed toward health care entities.

- Queries Analysis – Variations in querying by entities over time is being analyzed to improve understanding of entities' querying behavior, identify ways to encourage more consistent querying, and help entities maximize use of queries. This project includes identifying patterns of queries by types of entities; for example, cyclical patterns, batch queries, turnover in entities querying the data banks, and frequent and infrequent queriers. Monthly query data from SRA is being maintained in order to create a longitudinal file to analyze querying patterns over time.

For more information on the NPDB-HIPDB and its continuing improvements, visit the Web site at www.npdb-hipdb.com.

Medical Malpractice Payment Reporting

Malpractice Payment Reports Continue to Remain the Majority in the NPDB

Each year, Medical Malpractice Payment Reports represent the greatest proportion of reports contained in the NPDB, as shown in Figure 1. Although only physicians and dentists must be reported to the NPDB if an adverse action (except for exclusions, which are reportable for all health care practitioners) is taken against them, all licensed health care practitioners must be reported to the NPDB if a malpractice payment is made for their benefit.[12] The following narratives gives important details about the nature of these reports, including their number, their distribution among dentists, physicians and other practitioners, and variations in payment amounts and delays. For more information on malpractice reporting, see Tables 2 through 4 and 10 through 11 in the statistical section of this Annual Report.

Seven out of ten reports are for medical malpractice: Cumulative data show that at the end of 2001, 72.7 percent of all the NPDB's reports concerned malpractice payments. During 2002, the NPDB received 18,999 such reports (70.4 percent of all reports received).

Physicians are responsible for eight out of ten and dentists one out of ten Malpractice Payment Reports: Cumulatively, physicians were responsible for 181,073 (78.3 percent) of the NPDB's Malpractice Payment Reports. Dentists were responsible for 31,476 reports (13.6 percent), and all other types of practitioners were responsible for 18,690 reports (8.1 percent).

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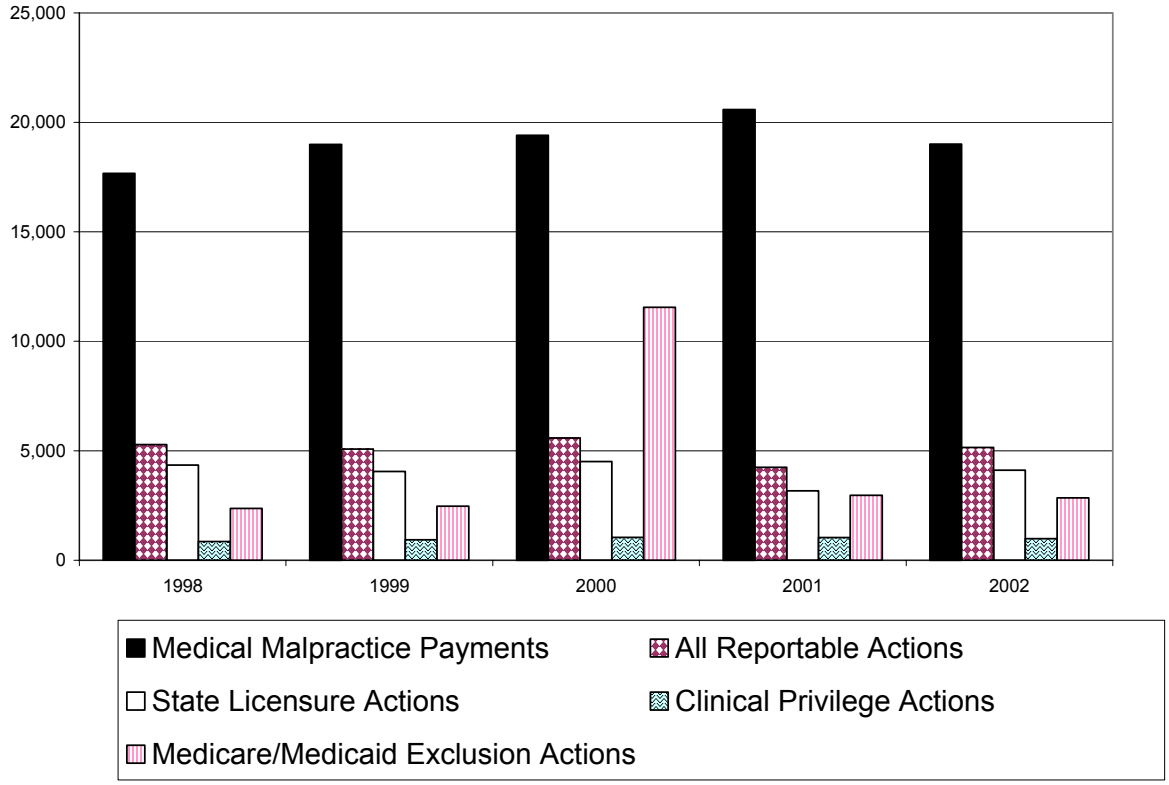
[12]Allopathic physicians; allopathic interns and residents; osteopathic physicians; and osteopathic physician interns and residents are all considered physicians for statistical purposes. Dentists and dentist residents are considered dentists for statistical purposes. For statistical purposes, the "other" category includes all remaining practitioner types which may be or have been reported to the NPDB: pharmacists; pharmacists (nuclear); pharmacy assistants; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; advanced practice nurses; clinical nurse specialists; licensed practical or vocational nurses; nurses aides; home health aides (homemakers); psychiatric technicians; dieticians; nutritionists; EMT, basic; EMT, cardiac/critical care; EMT, intermediate; EMT, paramedic; social workers; podiatrists; psychologists; clinical psychologists; school psychologists; psychological assistants, associates or examiners; audiologists; art/recreation therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitation therapists; speech/language pathologists; medical technologists; nuclear medicine technologists; cytotechnologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; chiropractors; dental assistants; dental hygienists; denturists; homeopaths; medical assistants; mental health counselors; midwives, lay (non-nurse); naturopaths; ocularists; opticians; optometrists; orthotics/prosthetics fitters; physician assistants, osteopathic; perfusionists; podiatric assistants; professional counselors; professional counselors (alcohol); professional counselors (family/marriage); professional counselors (substance abuse); respiratory therapists; respiratory therapy technicians; and any other type of health care practitioner which is licensed in one or more States.

Medical Malpractice Payment Reports, including those for physicians, decrease in number in 2002: The number of malpractice payments reported in 2002 (18,977) decreased by 7.7 percent from the number reported during 2001 (20,562). During 2002, physicians were responsible for 15,304 Malpractice Payment Reports (80.6 percent of all Malpractice Payment Reports received during the year). The number of physician malpractice payments reported decreased 8.2 percent from 2001 to 2002. In 2002 dentists were responsible for 2,087 Malpractice Payment Reports (11.0 percent). "Other practitioners" were responsible for 1,586 Malpractice Payment Reports (0.6 percent).

Figure 1: Number and Type of Reports Received by the NPDB (1998-2002)



Equipment/product incidents and miscellaneous incidents for physicians have both few reports and low payments: During 2002, incidents relating to miscellaneous and equipment/product related incidents had the lowest median payments ($30,500 and $45,000, respectively); they also had the lowest mean payments ($113,734 and $111,229, respectively). However, there were only 166 miscellaneous reports and 36 equipment/product related reports. Together they represented only 1.3 percent of all physician malpractice payments in 2002.

Obstetrics-related incidents have the biggest payments and diagnosis-related payments are the most reported for physicians in 2002: As in previous years, physicians' obstetrics-related cases (1,129 reports, 7.4 percent of all 2002 physician Malpractice Payment Reports) in 2002 had by far the highest median and mean payments ($265,200 and $497,121). In 2002, diagnosis-related payments for physicians totaling 5,611 (36.7 percent of all payments) were the most frequently reported.

Obstetrics-related incidents had the longest malpractice payment delays for physicians and anesthesia-related and equipment and product-related cases had the shortest mean and median payment delays for physicians: The 1,126 obstetrics-related physician payments in 2002 (5.9 percent of **all** 2002 payments) had the longest mean delay between incident and payment (5.56 years) and the longest median delay (4.63 years). The shortest average delay for 2002 physician malpractice payments was for anesthesia related cases (3.74 years). There were 467 such cases for physicians, representing 2.5 percent of all 2002 malpractice payments. The shortest median delay for 2002 physician payments was for equipment and product related cases (2.92 years). There were 36 such cases for physicians, representing 0.2 percent of all 2002 malpractice payments.

Median and mean malpractice payment delays for physicians range from 4.00 to 4.79 years: Cumulatively, the mean payment delay for all payments for physicians is 4.79 years and the median is 4.02 years. For 2002, the mean payment delay for all payments for physicians is 4.54 years and the median is 4.00 years.

Nurses, Physicians Assistants Are Reported for Malpractice Payments

Although physicians and dentists have the most Medical Malpractice Payment Reports in the NPDB, there are also many of these reports for nurses and physician assistants. There has been particular interest in both of these professions' reports, as shown in requests for information made to the DPDB, and the following describes the information the NPDB contains on them. The NPDB classifies registered nurses into five categories: Nurse Anesthetist, Nurse Midwife, Nurse Practitioner, Clinical Nurse Specialist/Advanced Practice Nurse[13], and Registered Nurse not otherwise classified, referred to in the tables as Registered Nurse. For more information about this reporting, see Tables 12 through 15 in the statistical section of this Annual Report.

Only about one out of 100 Malpractice Payment Reports are for nurses, most for non-specialized RNs: All types of Registered Nurses have been responsible for 4,075 malpractice payments (1.3 percent of all payments) over the history of the NPDB. Non-specialized Registered Nurses were responsible for 63.5 percent of the payments made for nurses. Nurse Anesthetists were responsible for 21.9 percent of nurse payments. Nurse Midwives were responsible for 8.6 percent, Nurse Practitioners were responsible for 5.9 percent, and Advanced Nurse Practitioners were responsible for 0.1 percent of all nurse payments.

Reasons for nurse Malpractice Payment Reports vary depending on specialty: Monitoring, treatment, and medication problems were responsible for the majority of payments for non-specialized nurses, but obstetrics and surgery-related problems were also responsible for significant numbers of payments for these nurses. As would be expected, anesthesia-related problems were responsible for 84.2 percent of the 891 payments for Nurse Anesthetists. Similarly, obstetrics-related problems were responsible for 80.5 percent of the 349 Nurse Midwife payments. Diagnosis-related problems were responsible for 47.1 percent of the 242 payments for Nurse Practitioners. Treatment-related problems were responsible for another 21.9 percent of payments for these nurses. Of the four reports for Advanced Nurse Practitioners, two were for treatment related problems, one was for an anesthesia related problem, and one was for a surgery related problem.

Median nurse payment amounts are smaller than physicians', but mean nurse payment amounts are larger: The median and mean payment for all types of nurses in 2002 was $122,500 and $310,867 respectively. The median nurse payment was $27,500 less than the median physician payment ($150,000) but the mean nurse payment was $63,273 larger than the mean physician payment in 2002 ($275,094). Similarly, the inflation-adjusted cumulative median nurse payment of $91,475 was $20,899 less than the $112,374 inflation-adjusted cumulative median payment for physicians. The inflation-adjusted cumulative mean nurse payment of $295,718 was $53,159 larger than the inflation-adjusted cumulative mean physician

[13]The category of Advanced Practice Nurse was added in 2001, but no reports for these practitioners were received until 2002. There were only four reports for these practitioners, which does not impact the numbers of nurse payments as a whole significantly.

payment of $242,559. The mean payment amount for nurses was likely larger because there were relatively fewer nurse payments, which means one significantly large payment can impact the mean more than if there were more nurse payments. The median payment amount was more representative of the payment amounts for physicians and nurses.

There is a wide variation in States' nurse malpractice payment reports compared to physicians' reports, which may show differences in safety of practice: Vermont had only four nurse Malpractice Payment Reports in the NPDB while New Jersey had the most (507). The ratio of nurse payment reports to physician payment reports (using adjusted figures) for Vermont (with only four nurse payments) was one of the lowest in the Nation at 0.01, but 12 States had only one nurse payment report for 100 or more physician payment reports. In contrast, the ratio for Idaho, which was the highest in the Nation, was 7.4 nurse payment reports for every 100 physician payment reports. Four other States also had ratios of more than 6 nurse payment reports for every 100 physician payment reports. If the number of reports was adjusted to account for reports concerning payments made by State malpractice funds, these adjusted reports accounted for only 1.5 percent of nurse payment reports. There may be several explanations for differences in the ratio of payment reports for nurses and physicians, including possible differences in the ratio of nurses to physicians in practice in the State.

Physician Assistants have less than one percent of all Medical Malpractice Payment Reports, most of them for diagnosis-related problems: Physician Assistants have been responsible for only 658 malpractice payments since the opening of the NPDB (0.28 percent of all payments). Both cumulatively and during 2002, diagnosis-related problems were responsible for well over half of all Physician Assistant malpractice payments (56.2 percent cumulatively and 68.5 percent in 2002). Treatment-related payments were the second largest category both cumulatively and in 2002 (25.4 percent and 16.9 percent, respectively).

Payments in the diagnosis-related category for Physician Assistants were larger than treatment-related payments: For 2002 there was one anesthesia related payment of $415,000 and one obstetrics payment of $125,000. Payments in the diagnosis category had a median payment amount of $100,000 in 2002 and a cumulative inflation-adjusted median payment amount of $91,981, while treatment-related payments had a median payment of $22,500 for 2002 and a cumulative inflation-adjusted median payment of about $25,000.

States Vary in Malpractice Payment Amounts and Times from Incident to Payments

States vary widely in the number of Medical Malpractice Reports for their practitioners, their mean and median medical malpractice amounts, and their "payment delay," which is how long it takes to receive a malpractice payment after an incident occurs. The following narrative examines these differences in detail. For more information on malpractice reporting among the States, see Tables 6 through 8 in the statistical section of this Annual Report.

"Adjusted" numbers of Medical Malpractice Payment Reports help to give more realistic picture of States payment reports: To make the statistics more informative and realistic, this narrative relies on an "adjusted" number of Malpractice Payment Reports, which excludes reports for malpractice payments made by State malpractice funds. Nine States[14] have or had such funds, and most, but not all, fund payments pertain to practitioners practicing in these States.

Usually when payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. These funds sometimes make payments for practitioners reported to the NPDB as working in other States. Payments by the funds are excluded from the "adjusted" counts so malpractice incidents are not counted twice.

Although the "adjusted" number is the best available indicator of the number of distinct malpractice incidents which result in payments, it is an imperfect measure. Some State funds are the primary insurer and only payer for some claims. Since these payments cannot be readily identified, they are excluded from the "adjusted" scores even though they are the only report in the NPDB for the incident. The "adjusted" counts also do not take into account insurers of last resort which, in most cases, provide primary coverage but which, in other cases, provide secondary coverage for payments over primary policy limits and report these over-limit payments.[15]

The ratio of physician payment reports to dental payment reports varies widely among the States: Nationally, there was about one dental adjusted Medical Malpractice Payment Report for every five of these reports for physicians. In California, Utah, and

[14]Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin.

[15]Kansas is an example of a state in which the fund is the primary carrier in some cases; the Kansas fund is the primary carrier for payments for practitioners at the University of Kansas Medical Center. New York is an example of a State with an insurer of last resort which sometimes provides over-limits coverage but usually is a practitioner's primary insurer.

Wisconsin, however, there was one dentist payment report for every 2.9 physician payment reports. In Mississippi, North Carolina, and West Virginia there was less than one dental payment report for every 10 physician payment reports. In States with relatively few physicians or dentists, the number of payment reports sometimes is heavily impacted by large numbers of reports for a single practitioner, which can skew comparisons between States. For example, the high ratio of dental payment reports to physician payment reports in Utah was largely the result of a very large number of payment reports for one dentist during 1994.

State reporting numbers can be affected by many settlements for a practitioner and delinquent reports: The number of reports in any given year in a State may be impacted by unusual circumstances, such as the settlement of a large number of claims against a single practitioner. State report counts may also be substantially impacted by other reporting artifacts, such as a reporter submitting a substantial number of delinquent reports at the same time. Indiana reporting, for example, was impacted by the NPDB's receipt of delinquent reports during 1996 and 1997.

States' malpractice statutes affect medical malpractice payment reporting numbers: The number of payment reports in any given State is affected by the specific provisions of the malpractice statutes in each State. Statutory provisions may make it easier or more difficult for plaintiffs to sue for malpractice and obtain a payment. For example, there are differences from State to State in the statute of limitations provisions governing when plaintiffs may sue. There also are differences in the burden of proof. Some States also limit payments for non-economic damages (e.g., pain and suffering). Payment limits may reduce the number of claims filed by reducing the total potential recovery and the financial incentive for plaintiffs and their attorneys to file suit, particularly for children or retirees who are unlikely to lose earned income because of malpractice incidents. Sometimes changes in malpractice statutes may be responsible for changes in the number of payment reports within a State observed from year to year. Changes in State statutes, however, are unlikely to explain differences in reporting trends observed for physicians and dentists within the same State. For example, the number of physician payment reports in Georgia steadily increased from 1998 to 2001 while the number of dentist payment reports stayed relatively level over the same period.

Median payment amounts for physician Medical Malpractice Payment Reports vary by thousands of dollars among the States: The cumulative median physician malpractice payment for the NPDB was $100,000 and the 2002 median payment was $150,000. Illinois, New Hampshire, Hawaii, and Pennsylvania all had the highest 2002 medians of $200,000 or more. The lowest 2002 median was found in Vermont at $40,865. Next lowest, Kentucky had a median payment of $49,000, Indiana, $50,000, and California, $67,500.[16] These numbers were

[16]The California median payment for physicians is artificially impacted by a State law which is commonly believed to require reporting to the State only malpractice settlements of $30,000 or more. During 2002, 1,685 (8.8 percent) of California physician's 19,231 malpractice payments were for $29,999. Payments for $29,999 are extremely rare in other States. Another 599 California payments were for exactly $30,000, which is immediately below the actual reporting threshold, which required reporting of malpractice payments over $30,000. California law requires reporting of malpractice arbitration awards, judgments and settlements after judgment regardless of payment amount. When these categories are combined, fully 12.0 percent of California physician malpractice payments are within $2.00 of the State reporting threshold.

not adjusted for the impact of State malpractice funds, which have the effect of lowering the observed mean and median payment. Because mean payments can be substantially impacted by a single large payment or a few such payments, a State's median payment is normally a better indicator of typical malpractice payment amounts.[17]

Mean "payment delays" for physician Medical Malpractice Payment Reports continue to decrease: "Payment Delay" is how long it takes to receive a malpractice payment after an incident occurs. For all physician Malpractice Payment Reports in the NPDB, the mean delay between incident and payment was 4.79 years. For 2002 payments, the mean delay was 4.54 years. Thus during 2002, payments were made on average about three months quicker than the average for all payments in the NPDB. Average payment delays continued to decrease in 2002. The average physician payment came about 14 days sooner than in 2001.

States vary widely in their "payment delays": On average, during 2002 payments were made most quickly in California (a mean payment delay of 2.95 years) and North Dakota (3.02 years). Payments were slowest in Rhode Island (6.42 years).

[17]Half the payments are larger and half the payments are smaller than the median payments. For example, consider the following eleven malpractice payments, $11,000; $12,000; $13,000; $14,000; $15,000; $16,000; $17,000; $18,000; $19,000; $20,000 and $1,000,000, the median payment is $16,000. The mean of these payments (the total divided by the number of payments is $105,000. Clearly the median is a better representation of the typical or "average" payment for this data than is the mean.

Three Issues – Corporate Shield, Federal Entity Policies, and Physician Residents – Affect Malpractice Payment Reporting

Three aspects of Malpractice Payment Reporting are of particular interest to reporters, queriers, practitioners, and policy makers. First, the "corporate shield" issue reflects possible under-reporting of malpractice payments. The second issue involves differences in reporting requirements for Federal agencies based on memoranda of understanding. The third issue, reporting physicians in residency programs, concerns the appropriateness of reporting malpractice payments made for the benefit of physicians in training who are supposed to be acting only under the direction and supervision of attending physicians.

"Corporate Shield" may mask the extent of substandard care and diminish NPDB's usefulness as a flagging system – Malpractice Payment Reporting may be affected by use of the "corporate shield." Attorneys have worked out arrangements in which the name of a health care organization (e.g., a hospital or group practice) is substituted for the name of the practitioner, who would otherwise be reported to the NPDB. This is most common when the health care organization is responsible for the malpractice coverage of the practitioner. Under current NPDB regulations, if a practitioner is named in the claim but not in the settlement, no report about the practitioner is filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement. The extent of the corporate shield cannot be measured with available data.

Federal agencies have made agreements with HHS for malpractice payment reporting to the NPDB: The HCQIA, as amended, directed the Secretary of HHS to enter into memoranda of understanding with the Secretaries of Defense and Veterans Affairs to apply the requirements of the law to hospitals, other facilities and health care providers under the jurisdiction of the agencies. Under the NPDB-DOD Memorandum of Agreement, the DOD reports malpractice payments to the NPDB only if the practitioner was responsible for an act or omission that was the cause of the harm that gave rise to the payment. Also, it is reported only if at least one of the following circumstances exists about the act or omission: (1) The Surgeon General of the affected military department (Air Force, Army, or Navy) determines that the practitioner deviated from the standard of care; (2) The payment was the result of a judicial determination of negligence and the Surgeon General finds that the court's determination was clearly based on the act or omission; and (3) The payment was the result of a settlement and the Surgeon General finds that based on the case's record as whole, the purpose of the NPDB requires that a report be made. Under the DVA Memorandum of Agreement, DVA uses a similar process when deciding whether to report malpractice payments.

The NPDB Executive Committee is examining the issue of required reporting of residents' malpractice payments: The HCQIA makes no exceptions for malpractice payments made for the benefit of residents. Payments for residents must be reported to the NPDB. Currently, a committee of the Executive Committee is examining the issues surrounding the

reporting of residents to the NPDB. They are considering both residents with primary responsibility (practicing independently) and residents with ancillary responsibility (training in a residency program under supervision). The issue of reporting residents has also been discussed in articles in the *Bulletin of the American College of Surgeons*.[18] A common misperception is that since residents act under the direction of supervising attending physicians, as long as they are acting within the bounds of their residency program, residents by definition are not responsible for the care provided. Therefore, it is incorrectly believed that regardless of whether or not they are named in a claim for which a malpractice payment is ultimately made, they should not be reported to the NPDB.

Physician interns and residents have 1,903 Medical Malpractice Payment Reports in the NPDB: At the end of 2002 a total of 1,331 physicians had Malpractice Payment Reports listing them as allopathic or osteopathic interns or residents at the time of the incident which led to the payment. Of these 1,331 physicians, 1,181 were allopathic residents and 150 were osteopathic residents. The NPDB contained a total of 1,903 intern or resident-related Malpractice Payment Reports for these practitioners (1,665 for allopathic interns or residents and 238 for osteopathic interns or residents). These payments constitute only 1.0 percent of all physician Malpractice Payment Reports cumulatively.

Most physician interns and residents have only one Medical Malpractice Payment Report: A total of 1,007 of the reported interns and residents had only one Malpractice Payment Report as an intern or resident; 216 had two such reports; one had nine reports; one had 11 reports; one had 12 reports; and one had 45 Malpractice Payment Reports for incidents while an intern or resident.

[18]Fischer, J.E. and Oshel, R.E. The National Practitioner Data Bank: What You Need to Know. *Bulletin of the American College of Surgeons.* June 1998, 83:2; 24-26. Fischer, J.E. The NPDB and Surgical Residents. *Bulletin of the American College of Surgeons*. April 1996. 81:4; 22-25. Ebert, P.A. As I See It. *Bulletin of the American College of Surgeons.* July 1996. 81:7; 4-5. See also reply by Chen, V. and Oshel, R. Letters, *Bulletin of the American College of Surgeons*, January 1997. 82:1; 67-68.

Adverse Actions and Exclusions Reporting

NPDB Receives Many Reports on Adverse Actions and Medicare/Medicaid Exclusions

Beyond Medical Malpractice Payment reports, which make up more than 70 percent of NPDB reports, the NPDB also receives many reports on "adverse actions[19]," which must be reported to the NPDB if they are taken against physicians and dentists. Since 1997, the NPDB has received Medicare/Medicaid exclusions taken against health care practitioners. The following gives significant details about these types of reports. For more information, see Tables 2 through 5 in the statistical section of this Annual Report.

Adverse Action Reports[20], almost one-third of all reports, rise over 10 percent in 2002, reversing last year's decline: Adverse actions represented 29.6 percent of all reports received during 2002 and, cumulatively, 27.3 percent of all NPDB reports. The number of Adverse Action Reports received increased by 776 reports to a total of 7,989 (a 10.8 percent increase) from 2001 to 2002. This followed a decrease of 9,915 reports from 2000 to 2001. This large decrease was mostly a result of a large decrease in Exclusion Reports; there were many more Exclusion Reports submitted in 2000 than usual because the HIPDB fully opened that year.

Licensure action reports, most of them for physicians, increase by about a third in 2002: During 2002, licensure actions made up 51.5 percent of all adverse actions and 15.2 percent of all NPDB reports (including malpractice payments and Medicare/Medicaid exclusions). They continued to represent the majority of adverse actions (cumulatively 51.4 percent of all adverse actions). Licensure reports increased by 29.7 percent from 2001 to 2002. Those for physicians increased by 32.8 percent in 2002. Licensure reports for dentists, in

[19] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

[20] Some Adverse Action Reports are non-adverse "Revisions." Of the 44,662 reported licensure actions in the NPDB, 4,153 reports or 9.3 percent were for licenses reinstated or restored. Of the 11,502 reported clinical privileges actions, 851 reports or 7.4 percent concerned reductions, reinstatements, or reversals of previous actions. Of the 431 reported professional society membership actions, 17 reports or 3.9 percent were reinstatements or reversals of previous actions. None of the 303 reported DEA Reports were considered non-adverse. Of the 29,993 Exclusion Reports, 3,360 or 11.2 percent are reinstatements.

contrast, increased only by 15.8 percent. Licensure reports for physicians constituted 83.8 percent of all licensure reports in 2002.

Clinical privileges action reports, making up only three percent of all 2002 NPDB reports, decrease slightly: There were 1,037 clinical privilege reports in 2001 and 988 in 2002, a decrease of 4.7 percent. Physician clinical privilege reports decreased by 3.4 percent.

Less than one percent of NPDB reports are for professional society membership actions and DEA actions: Professional society membership actions (only 47 reported) made up 0.1 percent of all adverse actions during 2002. No DEA reports were received during 2002. The number of reported professional society and DEA actions has remained almost negligible throughout the NPDB's history. Cumulatively and for 2002, DEA reports and professional society action reports together represented only 0.2 percent of all reports.

Physicians are responsible for most 2002 licensure, clinical privileges, and professional society membership actions and less than 15 percent of 2002 Medicare/Medicaid Exclusion Reports: During 2002, physicians were responsible for 83.8 percent of licensure actions, 94.1 percent of clinical privileges actions, and 85.1 percent of professional society membership actions. In contrast, physicians were responsible for only 14.6 percent of the Medicaid/Medicare Exclusion actions added to the NPDB during 2002.

Physicians are responsible for almost all physician and dentist clinical privilege reports: In 2002 physicians, representing about 81.5 percent of the nation's total physician-dentist workforce, were responsible for 83.8 percent of licensure reports for this workforce. They were also responsible for 98.0 percent of all clinical privilege reports for physicians and dentists. This result is expected, however, since dentists frequently do not hold clinical privileges at a health care entity and thus could not be reported for a clinical privileges action.

Dentists have a much smaller percentage of reports than physicians, along with smaller numbers of licensure action reports than in previous years: Dentists, who comprise approximately 18.5 percent of the nation's total physician-dentist workforce, were responsible for 16.2 percent of physician and dentist licensure actions, 0.2 percent of clinical privileges actions[21], 13.0 percent of professional society membership actions, no DEA actions, and 23.9 percent of exclusion actions for physicians and dentists in 2002. The number of dental licensure reports has generally grown each year, but 2002's figure of 668 reports represents the third smallest number of dental licensure actions submitted to the NPDB in a single year. In 1991 and 2001, these figures were 562 and 577, respectively.

Reporting of Medicare/Medicaid Exclusion Reports decreased from 2001: There were 2,965 Exclusion Reports in 2001 and 2,843 in 2002, a decrease of 4.1 percent. Physician Exclusion Reports decreased by 28.4 percent and Exclusion Reports for non-physicians/non-dentists increased by 3.7 percent to a total of 2,299. Exclusion Reports represented 10.5 percent of all 2002 reports and 9.4 percent of all NPDB reports cumulatively.

[21] This small percentage reflects the fact that relatively few dentists have hospital privileges.

The large increase in the number of Exclusion Reports for 2000 shown in Table 2 reflected reports for non-healthcare practitioners and nurse practitioners being submitted to the NPDB for 2000 and previous years. Exclusion Reports for non-healthcare practitioners are being removed from the NPDB.

Reports for "other practitioners" in 2002 are almost all for Medicare/Medicaid Exclusions: "Other practitioners" had 2,299 Exclusion Reports in 2002, which made up all their reports in 2002 except for 39 Clinical Privilege Reports and one Professional Membership Action Report. "Other practitioners" accounted for four-fifths of Exclusion Reports (80.9 percent of 2,843 reports) added to the NPDB during 2002. Entities are not required to report Clinical Privilege Reports and Professional Membership Action reports on "other practitioners" to the NPDB. Exclusion reports for "other practitioners" are required to be reported to the NPDB.

Cumulatively, almost all "other practitioners" reports are for Medicare/Medicaid Exclusions: "Other practitioners" had 22,693 Exclusion Reports in the NPDB, which was 98.2 percent of all their adverse action reports (they had only four Professional Membership Action Reports total). Cumulatively, "other practitioners" accounted for three-quarters of Exclusion Reports (75.7 percent of 29,993 reports) in the NPDB. "Other practitioners" are required to be reported for Exclusions to the NPDB.

Under-reporting Affects Numbers of Adverse Action Reports; States Vary in Reporting Activity

Two issues can affect the interpretation of the reporting of adverse actions – the under-reporting of clinical privileges actions and the reporting of adverse licensure actions for physicians and dentists practicing in-State. Both of them have an impact on how the information on Adverse Action Reports[22] should be viewed. The following narrative explores these issues in depth. For more in-depth data on these issues, see Tables 16 through 19 in the statistical companion to the Annual Report.

The frequency of reporting clinical privileges actions is being researched: In October 1996, the Northwestern University Institute for Health Services Research and Policy Studies, under contract with HRSA, held a conference on clinical privilege reporting by hospitals. Participants included executives from the American Medical Association; American Osteopathic Association; American Hospital Association; Joint Commission on Accreditation of Health Care Organizations; CMS; HHS OIG; DPDB, BHPr, HRSA, HHS (which manages the operations of the NPDB program); Federation of State Medical Boards; Public Citizen Health Research Group; Citizen Advocacy Center; individual State hospital associations; individual hospitals; and hospital attorneys.[23] There was agreement that research was needed to better understand clinical privileges reporting and to discover which steps could improve reporting. PriceWaterhouse Coopers through a contract with the Division of Practitioner Data Banks is researching the issue in 2003 and will produce a report on the subject.

Efforts to increase clinical privilege reporting and research into the issue of clinical privilege reporting are making a difference and are continuing: The NPDB and DPDB have been conducting research on the reporting issue and working with relevant organizations to try to ensure that actions that should be reported actually are reported. The 15.4 percent increase in clinical privilege reporting from 1998 to 2002 may reflect the results of this effort. However, even with the observed increase in reporting, the number of clinical privileges actions reported remains low. For this reason, PricewaterhouseCoopers was contracted by DPDB to develop and test a methodology for gaining access to needed records on clinical privileges actions to ensure compliance with NPDB reporting requirements. The project was designed to determine whether hospitals and managed care organizations will voluntarily participate in clinical privilege reporting compliance audits and to develop a methodology for such audits. Hospitals and

[22] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

[23] Institute for Health Services Research and Policy Studies, Northwestern University. HRSA Roundtable Conference Report.

Managed Care Organizations proved to be reluctant to participate in voluntary audits, although the methodology worked well in the few entities that agreed to participate in testing it.

Less than half of non-Federal hospitals with "active" NPDB registrations have reported an action to the NPDB: Percentages for States of "active" registered non-Federal hospitals that had never reported an action to the NPDB range from 26.7 percent in Rhode Island to 78.9 percent in South Dakota. As of December 31, 2002, 54.3 percent of non-Federal hospitals registered with the NPDB and in "active" status had never reported a clinical privileges action to the NPDB. This percentage of non-reporters has steadily decreased over the years. Analysis in a previous year showed that clinical privilege reporting seems to be concentrated in a few facilities even in States which have comparatively high over-all clinical privilege reporting levels. This pattern may reflect a willingness (or unwillingness) to take adverse clinical privileges actions more than it reflects a concentration of problem physicians in only a few hospitals.

States show extreme variations in clinical privilege reporting and adverse licensure reporting, apparently showing differences in willingness to take actions: The ratio of adverse clinical privilege reports (excluding reinstatements, etc.) to adverse licensure reports (again excluding reinstatements, etc.) ranges from a low of one adverse clinical privilege report for every 8.3 adverse licensure reports in Connecticut to a high of 1.05 adverse clinical privilege reports in Nebraska for every adverse licensure report (i.e., more adverse clinical privilege reports than adverse licensure reports). While these ratios reflect variations in the reporting of both licensure actions and clinical privileges actions, the extreme variation from State to State is instructive. It seems likely that the extent of the observed differences may reflect variations in willingness to take actions rather than a substantial difference in the conduct or competence of the physicians practicing in the various States.

Most licensure actions for physicians and dentists are adverse (i.e., are not reinstatements): For physicians, 88.8 percent of all licensure actions reported to the NPDB had been adverse in nature.[24] For dentists, about 94.1 percent had been adverse. In Nevada, all reported physician licensure actions had been adverse. This contrasts with South Carolina, in which only 73.1 percent of the physician licensure actions had been adverse.

One measure of how active States are in taking actions against dentists and physicians is their percentage of adverse licensure actions for in-State practitioners: Physicians and dentists are often licensed in more than one State. If one State takes a licensure action, other States often take a parallel or reciprocal action because of the first State's action. Typically the practitioner is actively practicing in the first State which takes action; actions taken by the other States in which the practitioner is licensed prevent the practitioner from shifting his or her practice to the other States, but these actions do not reflect the extent of actions taken by

[24] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

the boards in relation to problems occurring in their States. Licensure reports for States in which the physician or dentist is practicing (i.e. in-State practitioners) do show the extent of actions taken by these States. Therefore, States with a lower percentage of adverse licensure actions for in-State practitioners may not be as active in taking actions against practitioners as States with a higher percentage of these actions.

Overall, more than four-fifths of physicians' adverse licensure actions are for in-State physicians: Nationally, as a whole, 86.9 percent of licensure actions are both adverse and pertain to in-State physicians. There was a wide range of percentages, from a low of 60.6 percent of all adverse licensure actions for in-State physicians in the District of Columbia to a high of 99.5 percent in Colorado. Thirty States had more than 90 percent of their adverse licensure actions concerning in-State physicians. Physicians are more likely to practice in more than one State in areas such as the District of Columbia, which are highly urbanized and in close proximity to several States, than States like Colorado, in which the urban population is concentrated away from other States. This may result in smaller percentages of adverse licensure actions for in-State physicians for these States.

Almost all dentist licensure actions are adverse and affect in-State dentists: Nationally, as a whole, 97.6 percent of licensure actions are both adverse and pertain to in-State dentists. Percentages range from a low of 50.0 percent in North Dakota to a high of 100.0 percent in nineteen States, in which all dental licensure actions were adverse and pertained to in-State dentists.

Multiple Reports

Physicians With Multiple Reports Also Tend to Have Other Types of Reports

Most physicians had one report, usually a Medical Malpractice Report, but there were also some that had multiple reports of different types. There are certain characteristics of physicians with multiple reports of different types that the following narrative explains in detail. For more information about these characteristics, see Tables 20 and 21 in the statistical companion to the Annual Report.

Nearly two-thirds of physicians have only one report, one in five has only two reports, and very few have more than five: At the end of 2002, a total of 192,451 individual practitioners had disclosable reports in the NPDB. Of these, 132,895 (69.1 percent) were physicians. Most physicians (63.4 percent) with reports in the NPDB had only one report, but the mean number of reports per physician was 1.77. Physicians with exactly two reports made up 20.2 percent of the total. About 97.0 percent had five or fewer reports and 99.5 percent of physicians with reports had ten or fewer reports. Only 599 (0.5 percent of physicians with reports) had more than 10 reports.

Most physicians with reports have only one Medical Malpractice Payment Report: Of the 132,906 physicians with reports, 81,492 (61.3 percent) had only Malpractice Payment Reports; 8,563 (6.4 percent) had only licensure reports; 5,071 (3.8 percent) had only clinical privilege reports; and 2,977 (2.2 percent) had only Medicare/Medicaid Exclusion Reports.

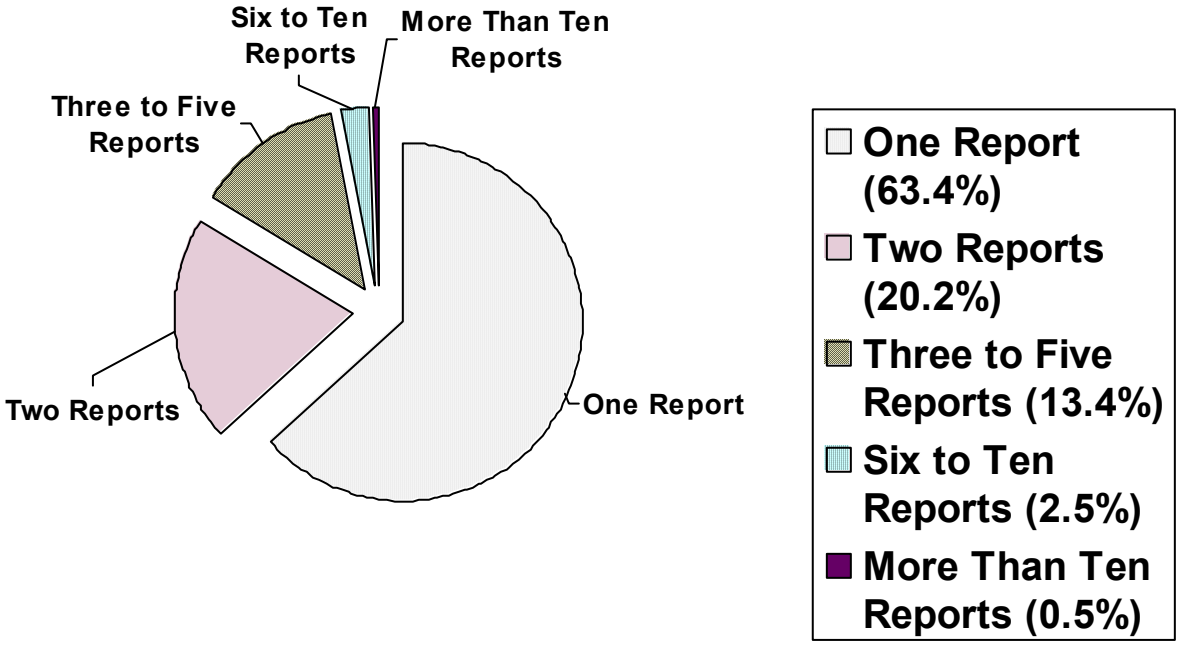
Less than one in twenty have a Malpractice Payment Report and another type of report: Notably, only 6,096 (4.6 percent) had at least one Malpractice Payment Report and at least one licensure report, and only 3,152 (2.4 percent) had at least one Malpractice Payment Report and at least one clinical privilege report. Only 1,384 (1.0 percent) had Malpractice Payment, licensure, and clinical privilege reports. Only 271 (0.2 percent) had at least one Malpractice Payment, licensure action, clinical privilege, and Exclusion Report at the end of 2002.

Physicians with high numbers of Malpractice Payment Reports tend to have at least some Adverse Action Reports[25] and Medicare/Medicaid Exclusion Reports, and vice versa: Although 94.8 percent of the 81,492 physicians with only one Malpractice Payment Report in the NPDB had no Adverse Action Reports, only 59.6 percent of the 333 physicians with ten or more Malpractice Payment Reports had no Adverse Action Reports. Generally, the data show that as a physician's number of Malpractice Payment Reports increases, the likelihood that the physician has Adverse Action Reports also increases. However, the trend reverses for physicians with

[25] Adverse Action Reports discussed in this paragraph do not include Medicare/Medicaid Exclusion Reports.

eight or more Adverse Action Reports[26]. One explanation may be that physicians with large numbers of Adverse Action Reports leave the profession and no longer have the opportunity to commit malpractice.

Figure 2: Percentage of Physicians with Number of Reports in the NPDB (1990-2002)



Physicians with at least two Malpractice Payment Reports are responsible for the majority of Malpractice Payment Reports for physicians: Approximately 30.5 percent of the 117,272 physicians with at least one Malpractice Payment Report had two or more Malpractice Payment Reports. These 35,780 physicians had 99,685 Malpractice Payment Reports in the NPDB, representing 55.0 percent of the 181,177 Malpractice Payment Reports in the NPDB for physicians.

A few physicians are responsible for a large proportion of malpractice payment dollars paid: The one percent of physicians with the largest total payments in the NPDB were responsible for about 12 percent of all the money paid for physicians in malpractice judgments or settlements reported to the NPDB since its opening in 1990. The five percent of physicians with the largest total payments in the NPDB were responsible for just under a third of the total dollars paid for physicians over the period. Eleven percent of physicians were responsible for half of all malpractice dollars paid, or settlements from September 1, 1990 through March 31, 2003.

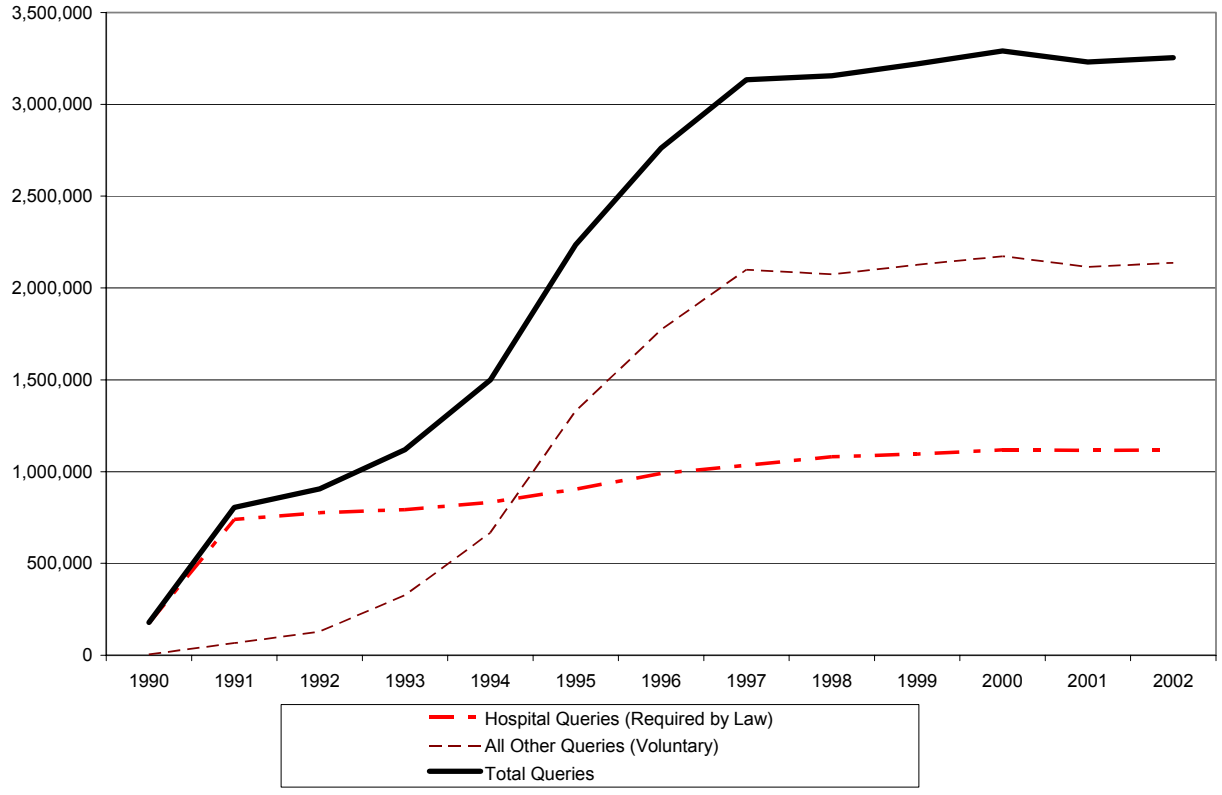
[26] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

Querying, Registration, and Secretarial Reviews

Querying Increased Slightly in 2002

The NPDB experienced a slight increase in querying during 2002. This was a reversal of the decline in querying last year, with a 0.7 percent increase in queries for 2002, from 3,231,086 in 2001 to 3,254,393 in 2002. The 2002 count represents an average of one query every 10 seconds. It is more than 4 times as many queries as the 809,844 queries processed during the NPDB's first full year of operation, 1991. Over the 12 years the NPDB has been open and extending to December 31, 2002, there have been cumulatively 28,795,703 entity queries. The following graph gives more information about the types of queries to the NPDB. For additional information about querying, see Tables 22, 23, and 24 in the statistical section of this Annual Report. For a visual portrait of voluntary and hospital querying, see Figure 2 below.

Figure 3: Queries by Querier Type (September 1, 1990 - December 31, 2002)



Entity queriers show they value information with large number of queries over NPDB's existence: Over time NPDB information has become much more valuable to users. The number of voluntary queries (those not required by law) from NPDB entities grew from 65,269 in 1991 to 2,134,993 in 2002, an increase of over 3,271 percent. Voluntary queries represented 65.6 percent of all entity queries during 2002.

Hospitals, which are required to query the NPDB, also have seen their queries grow: The growth in required queries by hospitals has not been as large as that of voluntary queriers. Their queries increased by 51.2 percent from 740,262 in 1991 (the NPDB's first full year of operation), to 1,119,400 queries in 2002. Hospitals are required to query for all new applicants for privileges or staff appointment, existing applicants when changes in privileges occur, and once every 2 years concerning their privileged staff. They made most of the queries to the NPDB in its first few years of operation. Hospitals may voluntarily query for other peer review activities, but for analysis purposes it is assumed all hospital queries are required.

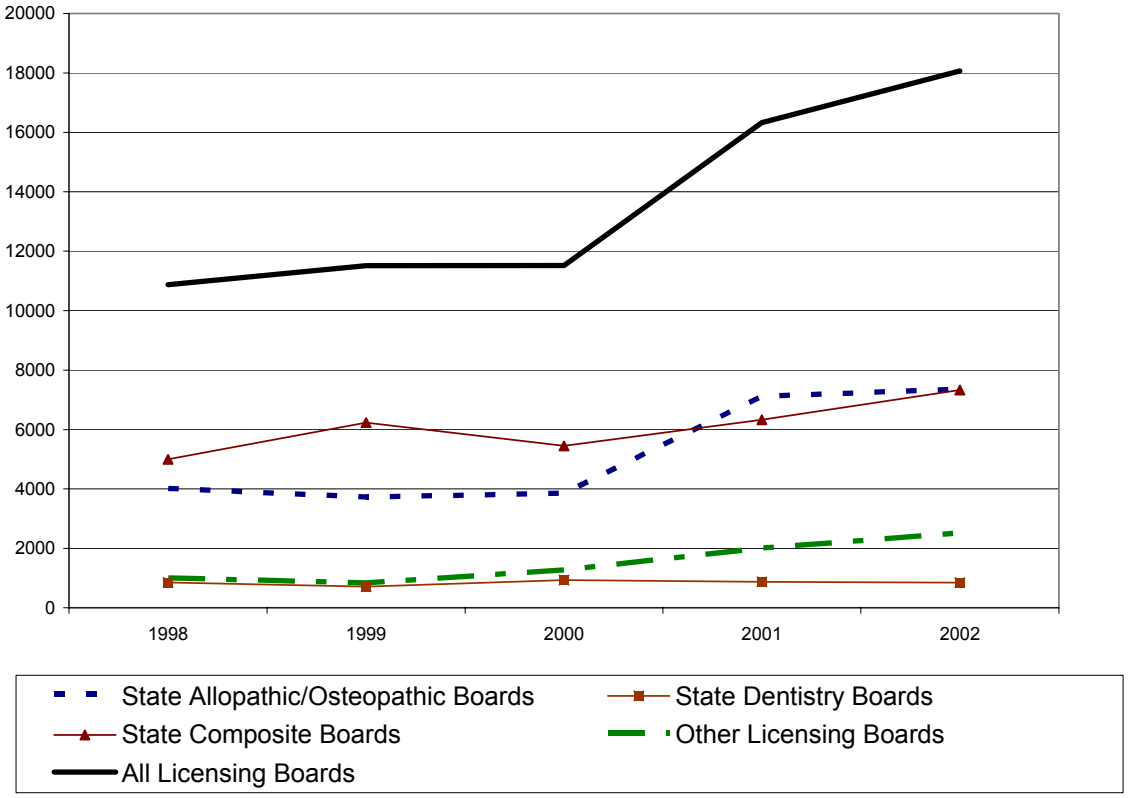
MCOs submit almost half of all voluntary entity queries: Managed care organizations (MCOs) are the most active voluntary queriers. MCOs in this case are defined as including HMOs and PPOs. Although they represented 9.6 percent of all querying entities during 2002 and 12.1 percent of all entities that have ever queried the NPDB, they made 50.0 percent of all queries during 2002 and have been responsible for 45.4 percent of queries ever submitted to the NPDB.

State licensing boards saw a large increase in queries: State licensing boards made 0.6 percent of queries during 2002 and 0.5 percent cumulatively. (The low volume of State board queries may be explained by the fact that entities are required to provide State boards copies of reports when they are sent to the NPDB so the boards do not need to query to obtain reports for in-State practitioners and by the fact that some boards require practitioners to submit self-query results with applications for licensure.) Figure 4 on the next page shows the number of State board queries by year. Part of the large increase in State board queries was largely due to an increase from 2000 to 2001 of more than 3,000 queries by the Maryland Board of Physician Quality Assurance, which queried on all its licensees. State composite boards are boards that cover more than one type of practitioner, such as both physicians and nurses.

Other entities also requested information from the NPDB: Other health care entities (i.e., non-hospitals and non-managed care organizations) made 14.8 percent of the queries in 2002 and 12.9 percent cumulatively. Professional societies were responsible for 0.2 percent of queries during 2002 and cumulatively.

Entities submit most queries for physicians, interns and residents: Queriers request information on many types of practitioners, but mostly query on physicians and dentists. During a sample period in October and November 2002, allopathic physicians were the subject of by far the most queries; more than 62.36 percent of queries submitted concerned allopathic physicians, interns and residents. The second largest category, clinical social workers, accounted for 6.08 percent of all queries. Dentists accounted for 4.64 percent, optometrists accounted for 3.73 percent, osteopathic physicians accounted for 3.71 percent, and chiropractors accounted for 3.25 percent.

Figure 4: Number of State Licensing Board Queries by Year (1998-2002)



Cumulatively, almost one out of ten self-queries result in a match: Practitioners who want to verify their record (or lack of a record) in the NPDB can query (self-query) on their own record at any time. Cumulatively from the opening of the NPDB, 413,775 self-queries have been processed; 33,930 (8.2 percent) of these queries were matched with reports in the NPDB.

Self-queries increased slightly during 2002, but most do not show reports for practitioners: The NPDB processed 37,804 self-query requests during 2002. The 2002 number of self-queries represented an increase of 3.3 percent from the number of self-queries processed during 2001 but represented a decrease of 28.1 percent from the record 52,603 self-queries processed during 1997. Of the self-query requests during 2002, 3,763 (10.0 percent) were matched with reports in the NPDB.

Query match rate continued to rise in 2002: When an entity submits a query on a practitioner, a match occurs when that individual is found to have a report in the NPDB. The 441,158 entity queries matched during 2002 represented a match rate of 13.5 percent. Although the match rate has steadily risen since the opening of the NPDB, we hypothesize that it will plateau once the NPDB has been in operation for the same length of time as the average practitioner practices, all other factors (such as malpractice payment rates for older and younger physicians) remaining constant.

A "no match" response is useful and valuable to queriers: About 86.5 percent of entity queries submitted in 2002 received a "no match" response from the NPDB, meaning that the practitioner in question does not have a report in the NPDB. This does not mean, however, that there was no value in receiving these responses. In a 1999 study of NPDB users by the Institute for Health Services Research and Policy Studies at Northwestern University and the Health Policy Center Survey Research Laboratory at the University of Illinois at Chicago, three-quarters of surveyed queriers rated NPDB information a "six" or a "seven," with seven representing "very useful" on a one to seven scale. A majority of surveyed queriers rated NPDB information influential in decision-making regarding practitioners (6 and 7 on a 7 point scale). At the end of 2002, a "no match" response to a query confirmed that a practitioner has had no reports in over 12 years. These responses will become even more valuable as the NPDB continues to receive reports.

Most Entities Registered With NPDB are Hospitals, MCOs

The National Practitioner Data Bank (NPDB) receives information from and provides information to registered entities that certify that they meet the eligibility requirements of the HCQIA. The following gives some information about these entities. Some entities have (or had in the past) multiple registration numbers either simultaneously or sequentially, so the data may not necessarily reflect the actual number of individual entities which have reported to or queried the NPDB. For more information, see Table 25 in the statistical section of the Annual Report.

Almost half of registered entities that have reported or queried are hospitals: A total of 13,034 registered entities were active, meaning they had reported or queried at least once, as of December 31, 2002. At the end of 2002, hospitals accounted for 6,200 (47.6 percent) of the NPDB's active registered entities. Managed Care Organizations accounted for 1,324 active registrations (10.2 percent), and other Health Care Entities[27] held 4,879 active registrations (37.4 percent). The 347 malpractice insurers with active registrations accounted for only 2.7 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB's active registrations at the end of 2002.

Almost half of registered entities active at any time over the NPDB's existence are hospitals: A total of 17,290 registered entities were ever active over the NPDB's existence. Hospitals accounted for 7,698 (44.5 percent) of the entities which had ever registered with the NPDB and had queried or reported at least once. MCOs accounted for 2,025 registrations at any time (11.7 percent), and other Health Care Entities held 6,406 registrations (37.1 percent). The 739 malpractice insurers ever registered accounted for only 4.3 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB's registrations throughout its existence.

[27]Other Health Care Entities must provide health care services and follow a formal peer review process to further quality health care. The phrase "provides health care services" means the delivery of health care services through any of a broad array of coverage arrangements or other relationships with practitioners by either employing them directly, or through contractual or other arrangements. This definition specifically excludes indemnity insurers that have no contractual or other arrangement with physicians, dentists, or other health care practitioners. Examples of other health care entities may include nursing homes, rehabilitation centers, hospices, renal dialysis centers, and free-standing ambulatory care and surgical service centers.

Secretarial Reviews, Mostly for Adverse Action Reports, Increased in 2002

In the dispute and Secretarial Review process, practitioners get a chance to challenge reports that they feel should not be in the data bank(s) because they are either inaccurate or should not have been filed under data bank(s) regulations. Only a small percentage of reports are disputed, though, and those that go through Secretarial Review usually are upheld by the Secretary as being accurate and reportable. The following narrative explains the process of NPDB disputes and Secretarial Reviews. For more information about Secretarial Review data, see Tables 26, 27, and 28 in the statistical section of the Annual Report.

Practitioners must go through an established administrative process when disputing a report, including working through the reporting entity to change the report: When practitioners are notified of a report in the NPDB-HIPDB that they believe is inaccurate or should not have been filed, they must first contact the reporting entity to correct the matter. If the reporting entity will not change the report, practitioners may dispute a report, add a statement to it, or both. (Practitioners may add a statement to a report even if they do not dispute the report.) When the NPDB-HIPDB receives a dispute from a practitioner, notification of the dispute is sent to all queriers who received the report within the last 3 years and is included with the report when it is released to future queriers.

If the reporting entity does not change the disputed report to the practitioner's satisfaction, then the practitioner may ask the Secretary of HHS to review the disputed report: When asking for Secretarial Review, the practitioner must send documentation to the NPDB-HIPDB that briefly discusses the facts in dispute, documents the inaccuracy of the report, and proves that he or she tried to resolve the disagreement with the reporting entity.

Secretarial Reviews are limited to accuracy and appropriateness of reporting, not the underlying decision to make a malpractice payment or take an adverse action: Secretarial Review does not include a review of the merits of a medical malpractice claim or the basis for an adverse action. Reviews are limited to factual accuracy and whether the report was submitted in accordance with the NPDB reporting requirements. All other reasons (such as a claim that although a malpractice payment was made for the benefit of the named practitioner, the named practitioner did not really commit malpractice or that there were extenuating circumstances) are "outside the scope of review." Factual accuracy means that the report accurately described the practitioner and the payment or action and reasons for the payment or action as reflected in decision documents.

Reviewed reports can be determined to be accurate or inaccurate: If the Secretary concludes the information in the report is accurate, the Secretary sends an explanation of the decision to the practitioner. The practitioner may then submit, within 30 days, a statement (limited to 2,000 characters) that is added to the report. If a report is determined to be

inaccurate, the Secretary notes the correction in the report. The Secretary can only remove a report from the NPDB if it was not legally required or permitted to be submitted.

Issues raised also can be determined to be "outside the scope of review": The Secretary also may conclude that the issue in dispute is outside the scope of review, i.e., that the only issues raised concern whether a payment should have been made or an action should have been taken. The Secretary cannot substitute his or her judgment on the merits for that of the entity that made the payment or took the action. In such cases determined to be "outside the scope of review," the Secretary directs the NPDB-HIPDB to add an entry to that effect to the report and to remove the dispute notation from the report. The practitioner may also submit a statement that is added to the report.

Reviews may be administratively dismissed or reconsidered: The Secretary may administratively dismiss requests for Secretarial Review if the practitioner does not provide required information or if the matter is resolved with the reporting entity to the satisfaction of the practitioner while the Secretarial Review is in process. Practitioners may ask for a reconsideration of a Secretarial Review decision.

Queriers are informed about a report's accuracy being disputed: Practitioners who have disputed reports must attempt to negotiate with entities that filed the reports to revise or void the reports before requesting Secretarial Review. The fact that a report is disputed simply means that the practitioner disagrees with the accuracy of the report. When disputed reports are disclosed to queriers, they are notified that the practitioner disputes the accuracy of the report.

The majority of disputed reports are for medical malpractice payments: At the end of 2002, a total of 12,449 reports, or 3.9 percent of reports, were under dispute. This number was made up of 1,909 licensure reports, 1,657 clinical privilege reports, 30 professional society membership reports, 13 DEA reports, 256 exclusion actions, and 8,584 Malpractice Payment Reports under dispute by the practitioners named in the reports. Exclusion Reports for actions taken prior to August 21, 1996[28] cannot be disputed with the NPDB.

Clinical privilege reports have the biggest percentage of reports that are disputed among the types of reports: Disputed reports constituted 4.3 percent of all licensure reports, 14.4 percent of all clinical privilege reports, 6.9 percent of professional society membership reports, 4.3 percent of DEA reports, and 3.7 percent of Malpractice Payment Reports.

Secretarial Reviews increased by a third from 2001 to 2002: Requests for review by the Secretary increased by 35.6 percent from 2001 to 2002. A total of 119 requests for review by the Secretary were received during 2002 compared to 87 in 2001. Bearing in mind that requests for Secretarial Review during a given year cannot be tied directly to either reports or disputes

[28]Exclusion actions taken before August 21, 1996 are included in the NPDB by a memorandum of agreement between HRSA, Centers for Medicare and Medicaid Services (formerly HCFA), and Department of Health and Human Services Office of Inspector General. Exclusion actions taken on August 21, 1996 and later are reported to the HIPDB by law and are disputed under the normal process. HIPDB Secretarial Review decisions on these reports also apply to the NPDB.

received during the same year, we can still approximate the relationship between requests for Secretarial Review, disputes, and reports. During 2002, the number of new requests for Secretarial Review was less than a 0.5 percent of the number of new Malpractice Payment Reports and Adverse Action Reports received by the NPDB.

Adverse Action Reports[29] were more likely to be appealed to the Secretary than were Malpractice Payment Reports: During 2002, 70.3 percent (83 requests) of all requests for Secretarial Review concerned adverse actions (i.e., licensure, clinical privileges, or professional society membership reports) even though only 19.1 percent of all 2002 reports fell in this category. While about three-fourths of reports in the NPDB are for medical malpractice payments, seven out of ten of the reports in Secretarial Review are for Adverse Action Reports. Within the adverse action category, clinical privilege reports represented almost half of all reports involved in Secretarial Review.

Most resolved Secretarial Reviews in 2002 resulted in unchanged reports: At the end of 2002, 62 (52.5 percent) of the 119 requests for Secretarial Review received during the year remained unresolved. Of the 56 new 2002 cases which were resolved, only three (2.5 percent) were voided. Reports were not changed (Secretary maintained report as submitted or Secretary decided the Secretarial Review request was outside the scope of review[30]) in 46 cases (80.4 percent) of the 2002 cases which were resolved.

More than one in seven Secretarial Reviews have resulted in outcomes that were beneficial for the practitioners: By the end of 2002, 15.4 percent of all closed requests for Secretarial Review had resulted in outcomes that were beneficial to the practitioner (a void of a report, a change in the report, or a closure because of an intervening action, such as the entity changing the report to the practitioner's satisfaction.) At the end of 2002, 6.5 percent of all requests for Secretarial Review remained unresolved. Only 63 (10.5 percent) of the total of 602 Malpractice Payment Reports with completed Secretarial Reviews (the total number of requests minus the number of unresolved requests) have resulted in outcomes that were beneficial to the practitioner. In the case of reviews of clinical privileges actions, 101 (16.0 percent) of the 630 closed requests resulted in a positive outcome. For licensure actions, 68 (22.2 percent) of the 306 closed requests resulted in a positive outcome, and for professional society membership actions, five closed requests resulted in a positive outcome.

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[29] "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

[30] Out-of-scope determinations are made when the issues at dispute can not be reviewed because they do not challenge the information's accuracy or its requirement to be reported to the NPDB, e.g. the practitioner claims not to have committed malpractice. The Secretary can only determine whether a payment was made. If a payment was made, the report must remain in the NPDB. Whether or not the practitioner committed malpractice is not relevant to keeping the payment report in the NPDB.

NPDB: Now and in the Future

Conclusion: NPDB Continues to Grow, Become More Useful

The total number of reports in the NPDB now exceeds 318,000 and the cumulative number of queries is more than 28 million. Although Medical Malpractice Payment Reports still represent the majority of reports in the NPDB, an increasing number of Adverse Action Reports (e.g., Medicare/Medicaid exclusions, licensure, clinical privileges, professional society membership, and Federal Licensure and DEA reports) have been entered into the NPDB. From 2001 to 2002, queries and submission of Adverse Action Reports both increased, reversing last year's decline. Several compliance projects are studying ways to make sure that the NPDB is receiving all the reports it should be, data improvement efforts are ensuring the accuracy of NPDB reports, and a project to market the benefits of the NPDB to reporters and queriers is being implemented.

As NPDB information accumulates, the NPDB's value as a source of aggregate information and its public use data for research increases, and its usefulness as an information clearinghouse for eligible queriers about specific practitioners grows. Over time, the data generated will provide useful information on trends in malpractice payments, adverse actions, and professional disciplinary behavior. Most importantly, however, the NPDB will continue to benefit the public by serving as an information clearinghouse that facilitates comprehensive peer review, and thereby, improves U.S. health care quality.

The "Third Generation" contract for the data banks continues to update and improve the Integrated Querying and Reporting Service (IQRS). System improvements – such as the response time to users being cut from 3 to 4 hours to 1 to 2 hours and allowing entities to now designate their agents for reporting and querying online – continue to be made to better serve the NPDB's customers. The continuing work to educate users about the NPDB and improve the data and its reporting ensures the NPDB will remain a prime source of medical malpractice and disciplinary information. This supports the legislative intent to protect the public by restricting the ability of incompetent or unprofessional practitioners to move from State to State without disclosure or discovery of their past history.

The NPDB to Continue Improving Its Operations in 2003

The NPDB plans several improvements to its operations and future policy initiatives in 2003. It will also continue updating and organizing its Web site, www.npdb-hipdb.com, to make it easier for customers to find information.

The following are improvements that will likely be made to the NPDB-HIPDB system in 2003:

- Report(s) will contain notices of when a Subject Notification Document of that report in the data banks fails to reach a practitioner by mail. In this manner, querying entities will be notified that a practitioner may not be aware of a report to the data banks.

- The look and feel of the IQRS will be updated to enhance consistency between the information Web site and the IQRS interface.

- The IQRS will allow on-line registration updates and registration renewal for entities. Entities are required to register with the data banks before they are allowed to report to or query them.

- The hardware used to run the IQRS will be upgraded. This includes a migration from SGI platforms running the UNIX Operating System to state-of-the-art Sun platforms running UNIX.

Some of the policy initiatives that will likely take place in 2003 include:

- The data banks will compare 2001 information from the National Association of Insurance Commissioners (NAIC) to 2001 data in the NPDB. The NAIC information comes from comparing the number of payments NAIC-reporting insurers made and the total amount they paid in "Annual Statements." The comparison's goals are to examine the level of compliance with Medical Malpractice Payment Reporting requirements, identify specific under-reporting insurers, and obtain required reports. If insurers discover unreported 2001 malpractice payments, they must submit reports on these payments to the NPDB.

- Continual reporting enforcement efforts, including comparing the data bank registrations of hospitals with the American Hospital Association (AHA) Guide, are ongoing to ensure all hospitals are querying and reporting to the data banks.

- The data banks are continuing to compare their physician licensure reports to information in the Federation of State Medical Board's Physician Data Center, which is a central repository for formal actions taken against physicians by State licensing and disciplinary boards. This comparison will help discover actions in the FSMB's Physician Data Center that State boards have not but should have reported to the data banks. The data banks will work with State boards to improve reporting.

Glossary of Acronyms

BHPr - Bureau of Health Professions

CMS - Centers for Medicare & Medicaid Services

DEA - Drug Enforcement Administration

HHS - Department of Health and Human Services

D.O. - Doctor of Osteopathy

DoD - Department of Defense

DPDB - Division of Practitioner Data Banks

DVA - Department of Veterans Affairs

HCQIA - Health Care Quality Improvement Act of 1986

HIPDB - Healthcare Integrity and Protection Data Bank

HMO - Health Maintenance Organization

HRSA - Health Resources and Services Administration

ICD - Interface Control Document

IQRS - Integrated Querying and Reporting Service

MCO - Managed Care Organization

M.D. - Doctor of Medicine (Allopathic Physician)

MMER - Medicare/Medicaid Exclusion Report

MMPR - Medical Malpractice Payment Report

MOU - Memorandum of Understanding

NAIC - National Association of Insurance Commissioners

NPDB - National Practitioner Data Bank

NPRM - Notification of Proposed Rule Making

OIG - Office of Inspector General

PPO - Preferred Provider Organization

PREP - Practitioner Remediation and Enhancement Partnership

SRA - SRA International, Inc.

Statistical Index: List of Tables

Table 1: Practitioners with Reports
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Practitioner Type	Number of Practitioners with Reports	Number of Reports*	Reports per Practitioner
Acupuncturists	60	62	1.03
Audiologists	25	27	1.08
Chiropractors	5,647	7,304	1.29
Counselors	472	567	1.20
Dental Assistants, Technicians, Hygenists	20	22	1.10
Dentists	26,375	42,626	1.62
Denturists	14	23	1.64
Dieticians	7	8	1.14
Emergency Medical Practitioners	118	147	1.25
Homeopaths and Naturopaths	11	16	1.45
Medical Assistants	24	25	1.04
Nurses and Nursing-related Practitioners	14,390	16,063	1.12
Occupational Therapists and Related Practitioners	50	52	1.04
Optical-related Practitioners	527	644	1.22
Pharmacists and Pharmacy Assistants	2,030	2,313	1.14
Physicial Therapists and Related Practitioners	646	688	1.07
Physician Assistants	766	880	1.15
Physicians**	132,895	235,209	1.77
Podiatrists and Podiatric-related Practitioners	3,635	6,242	1.72
Prosthetists	5	5	1.00
Psychiatric Technicians and Aides	11	19	1.73
Psychology-related Practitioners	1,135	1,509	1.33
Respiratory Therapists and Related Practitioners	30	31	1.03
Social Workers	189	224	1.19
Speech and Language-related Practitioners	3	3	1.00
Technologists	145	162	1.12
Non-Healthcare Practitioners	2,882	3,000	1.04
Unspecified or Unknown***	339	396	1.17
Total	**192,451**	**318,267**	**1.65**

* "Number of Reports" include medical malpractice payment reports, adverse licensure action reports, clinical privilege reports, professional society membership reports, Drug Enforcement Administration reports, and Medicare/Medicaid exclusion reports. Only physicians and dentists are reported for adverse licensure, clinical privilege, and professional society actions.

** Of physicians with reports at least 124,577 (93.7%) of them are allopathic physicians, interns, and residents; and at least 8,085 (6.08%) are osteopathic physicians, interns, and residents. Similarly, at least 219,683 (93.4%) of the physicians reports are for allopathic physicians, interns, and residents; and at least 15,284 (6.5%) of the physician reports are for osteopathic physicians, interns, and residents. The physician type could not be determined for 227 physicians responsible for 228 reports. The ratio of reports per practitioner for allopathic physicians was 1.76 and for osteopathic physicians was 1.89.

*** Reports with license summary information defined as "unspecified or unknown" or "non-healthcare practitioner" are Medicare/Medicaid exclusion reports. Reports for "non-healthcare practitioners" are being removed from the NPDB.

Table 2: Number and Percent Distribution of Reports by Report Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Report Type	1998		1999		2000		2001		2002		Cumulative	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Malpractice Payment Reports	**17,665**	**69.8%**	**18,998**	**71.6%**	**19,406**	**53.1%**	**20,587**	**74.1%**	**18,999**	**70.4%**	**231,377**	**72.7%**
Adverse Action Reports*	**7,651**	**30.2%**	**7,543**	**28.4%**	**17,128**	**46.9%**	**7,213**	**25.9%**	**7,989**	**29.6%**	**86,891**	**27.3%**
State Licensure	4,343	17.2%	4,058	15.3%	4,506	12.3%	3,169	11.4%	4,111	15.2%	44,662	14.0%
Clinical Privilege	856	3.4%	938	3.5%	1,049	2.9%	1,037	3.7%	988	3.7%	11,502	3.6%
Professional Society Membership	31	0.1%	18	0.1%	28	0.1%	33	0.1%	47	0.2%	431	0.1%
DEA	56	0.2%	62	0.2%	0	0.0%	9	0.0%	0	0.0%	303	0.1%
Medicare/Medicaid Exclusion**	2,365	9.3%	2,467	9.3%	11,545	31.6%	2,965	10.7%	2,843	10.5%	29,993	9.4%
Total	**25,316**	**100.0%**	**26,541**	**100.0%**	**36,534**	**100.0%**	**27,800**	**100.0%**	**26,988**	**100.0%**	**318,268**	**100.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2002. The numbers of reports for 1998 through 2001 may differ from those shown in previous Annua Reports because of voided reports and the fact that modified reports (Correction and Revision to Action Reports) are counted in the year they were originally submitted, not the year they were modified.

* "Adverse Action Reports" include those reports as defined in footnote 1 on page 5 of this Annual Report.

** The large increase in the number of exclusion reports for 2000 reflects reports for non-healthcare practitioners and nurse practitioner reports being submitted to the NPDB for 2000 and previous years. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

Table 3: Number of Reports Received and Percent Change by Report Type, Last Five Year
National Practitioner Data Bank (January 1, 1998 - December 31, 2002

Report Type	1998		1999		2000		2001		2002	
	Number	% Change 1997-1998	Number	% Change 1998-1999	Number	% Change 1999-2000	Number	% Change 2000-2001	Number	% Change 2001-2002
Malpractice Payment Reports	**17,665**	**-3.4%**	**18,998**	**7.5%**	**19,406**	**2.1%**	**20,587**	**6.1%**	**18,999**	**-7.7%**
Adverse Action Reports*	**7,651**	**52.1%**	**7,543**	**-1.4%**	**17,128**	**127.1%**	**7,213**	**-57.9%**	**7,989**	**10.8%**
State Licensure	4,343	5.8%	4,058	-6.6%	4,506	11.0%	3,169	-29.7%	4,111	29.7%
Clinical Privilege	856	-1.3%	938	9.6%	1,049	11.8%	1,037	-1.1%	988	-4.7%
Professional Society Membership	31	-3.1%	18	-41.9%	28	55.6%	33	17.9%	47	42.4%
DEA	56	115.4%	62	10.7%		…	9	…		…
Medicare/Medicaid Exclusion**	2,365	-69.7%	2,467	4.3%	11,545	368.0%	2,965	-74.3%	2,843	-4.1%
Total	**25,316**	**-18.7%**	**26,541**	**4.8%**	**36,534**	**37.7%**	**27,800**	**-23.9%**	**26,988**	**-2.9%**

This table includes only disclosable reports in the NPDB as of December 31, 2002. The numbers of reports for 1998 through 2001 may differ from those shown previous Annual Reports because of voided reports and the fact that modified reports (Correction and Revision to Action Reports) are counted in the year they were originally submitted, not the year they were modified.

Percent changes that cannot be calculated because no reports were submitted for specified periods are indicated by "…"

* "Adverse Action Reports" include those reports as defined in footnote 1 on page 5 of this Annual Report.

** The large increase in the number of exclusion reports for 2000 reflects reports for non-healthcare practitioners and nurse practitioners being submitted to the NPDB for 2000 and previous years. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

Table 4: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Practitioner Type	1998			1999			2000		
	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999	Number	Percent	% Change 1999-2000
Physicians	14,079	79.7%	-3.6%	15,103	79.6%	7.3%	15,564	80.4%	3.1%
Dentists	2,348	13.3%	-3.3%	2,351	12.4%	0.1%	2,351	12.1%	0.0%
Other Practitioners*	1,236	7.0%	-1.5%	1,531	8.1%	23.9%	1,444	7.5%	-5.7%
Total	**17,663**	**100.0%**	**-3.4%**	**18,985**	**100.0%**	**7.5%**	**19,359**	**100.0%**	**2.0%**

Practitioner Type	2001			2002			Cumulative	
	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002	Number	Percent
Physicians	16,669	81.1%	7.1%	15,304	80.6%	-8.2%	181,073	78.3%
Dentists	2,316	11.3%	-1.5%	2,087	11.0%	-9.9%	31,476	13.6%
Other Practitioners*	1,577	7.7%	9.2%	1,586	8.4%	0.6%	18,690	8.1%
Total	**20,562**	**100.0%**	**6.2%**	**18,977**	**100.0%**	**-7.7%**	**231,239**	**100.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2002. The numbers of reports for 1998 through 2001 may differ from those shown in previous Annual Reports because of modifications and voided reports. Modified reports are counted in the year they were originally submitted, not the year they were modified. The physician category includes allopathic and osteopathic physicians, interns and residents. The dentist category includes dental residents.

* "Other Practitioners" includes other healthcare practitioners, non-healthcare professionals and non-specified professionals. The total excludes practitioners for whom practitioner type was unidentified.

Table 5: Number, Percent Distribution, and Percent Change of Adverse Action and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

	1998			1999			2000			2001			2002			Cumulative	
Report Type	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002	Number	Percent
State Licensure Total	**4,343**	**56.8%**	**5.8%**	**4,058**	**53.8%**	**-6.6%**	**4,506**	**26.3%**	**11.0%**	**3,169**	**43.9%**	**-29.7%**	**4,111**	**51.5%**	**29.7%**	**44,662**	**51.4%**
Physicians	3,495	45.7%	6.5%	3,168	42.0%	-9.4%	3,479	20.3%	9.8%	2,592	35.9%	-25.5%	3,443	43.1%	32.8%	35,830	41.2%
Dentists	848	11.1%	3.2%	861	11.4%	1.5%	1,027	6.0%	19.3%	577	8.0%	-43.8%	668	8.4%	15.8%	8,803	10.1%
Other Pracitioners*	0	0.0%	0.0%	29	0.4%	…	0	0.0%	…	0	0.0%	…	0	0.0%	…	29	0.0%
Clinical Privilege Total	**856**	**11.2%**	**-1.3%**	**938**	**12.4%**	**9.6%**	**1,049**	**6.1%**	**11.8%**	**1,037**	**14.4%**	**-1.1%**	**988**	**12.4%**	**-4.7%**	**11,502**	**13.2%**
Physicians	799	10.4%	-4.4%	880	11.7%	10.1%	968	5.7%	10.0%	963	13.4%	-0.5%	930	11.6%	-3.4%	10,926	12.6%
Dentists	24	0.3%	118.2%	20	0.3%	-16.7%	24	0.1%	20.0%	39	0.5%	62.5%	19	0.2%	-51.3%	216	0.2%
Other Practitioners*	33	0.4%	65.0%	38	0.5%	15.2%	57	0.3%	50.0%	35	0.5%	-38.6%	39	0.5%	11.4%	360	0.4%
Professional Society Membership Total	**31**	**0.4%**	**-3.1%**	**18**	**0.2%**	**-41.9%**	**28**	**0.2%**	**55.6%**	**33**	**0.5%**	**17.9%**	**47**	**0.6%**	**42.4%**	**431**	**0.5%**
Physicians	30	0.4%	0.0%	18	0.2%	-40.0%	26	0.2%	44.4%	23	0.3%	-11.5%	40	0.5%	73.9%	387	0.4%
Dentists	1	0.0%	-50.0%	0	0.0%	-100.0%	0	0.0%	…	9	0.1%	0.0%	6	0.1%	…	40	0.0%
Other Practitioners*	0	0.0%	…	0	0.0%	…	2	0.0%	…	1	0.0%	0.0%	1	0.0%	0.0%	4	0.0%
DEA Total	**56**	**0.7%**	**…**	**62**	**0.8%**	**10.7%**	**0**	**0.0%**	**-100.0%**	**9**	**0.1%**	…	**0**	**0.0%**	**…**	**303**	**0.3%**
Physicians	52	0.7%	…	55	0.7%	5.8%	0	0.0%	-100.0%	9	0.1%	…	0	0.0%	…	292	0.3%
Dentists	4	0.1%	…	6	0.1%	…	0	0.0%	-100.0%	0	0.0%	…	0	0.0%	…	10	0.0%
Other Practitioners	0	0.0%	…	1	0.0%	…	0	0.0%	…	0	0.0%	…	0	0.0%	…	1	0.0%
Medicare/Medicaid Exclusion Total**	**2,365**	**30.9%**	**…**	**2,467**	**32.7%**	**4.3%**	**11,545**	**67.4%**	**368.0%**	**2,965**	**41.1%**	**-74.3%**	**2,843**	**35.6%**	**-4.1%**	**29,993**	**34.5%**
Physicians	572	7.5%	…	465	6.2%	-18.7%	2,266	13.2%	387.3%	578	8.0%	-74.5%	414	5.2%	-28.4%	5,468	6.3%
Dentists	205	2.7%	…	168	2.2%	-18.0%	663	3.9%	294.6%	169	2.3%	-74.5%	130	1.6%	-23.1%	1,832	2.1%
Other Practitioners*	1,588	20.8%	…	1,834	24.3%	15.5%	8,616	50.3%	369.8%	2,218	30.8%	-74.3%	2,299	28.8%	3.7%	22,693	26.1%
Total	**7,651**	**100.0%**	**-40.4%**	**7,543**	**100.0%**	**-1.4%**	**17,128**	**100.0%**	**127.1%**	**7,213**	**100.0%**	**-57.9%**	**7,989**	**100.0%**	**10.8%**	**86,891**	**100.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2002. The numbers of reports for 1998 through 2000 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Percent changes that cannot be calculated when no reports were submitted for specified periods are indicated by "…"

* "Adverse Action Reports" include those reports as defined in footnote 1 on page 5 of this Annual Report.

* "Other Practitioners" includes all other healthcare practitioners, non-healthcare professionals, and non-specified professionals.

** Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated. The number of exclusion reports in 2001 includes those reported to the HIPDB and the NPDB. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

Table 6: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Practitioner Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	Physicians		Dentists		Ratio of Adjusted Physician Reports to Adjusted Dentist Reports	Ratio of Adjusted Dentist Reports to Adjusted Physician Reports
	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*		
Alabama	752	743	152	152	4.89	0.20
Alaska	226	226	60	59	3.83	0.26
Arizona	2,786	2,770	464	464	5.97	0.17
Arkansas	860	853	134	134	6.37	0.16
California	19,231	19,207	6,495	6,495	2.96	0.34
Colorado	1,930	1,914	377	377	5.08	0.20
Connecticut	1,814	1,810	461	461	3.93	0.25
Delaware	445	433	56	56	7.73	0.13
District of Columbia	715	712	118	118	5.72	0.17
Florida*	12,203	12,154	1,582	1,582	7.68	0.13
Georgia	3,047	3,035	589	589	5.15	0.19
Hawaii	415	415	108	108	3.84	0.26
Idaho	366	365	50	50	7.30	0.14
Illinois	7,663	7,650	1,269	1,269	6.03	0.17
Indiana*	3,461	2,380	358	332	7.17	0.14
Iowa	1,443	1,440	178	178	8.09	0.12
Kansas*	2,024	1,361	211	209	6.51	0.15
Kentucky	1,929	1,915	317	317	6.04	0.17
Louisiana*	3,248	2,302	340	324	7.10	0.14
Maine	489	489	93	93	5.26	0.19
Maryland	2,854	2,849	738	738	3.86	0.26
Massachusetts	3,280	3,274	847	847	3.87	0.26
Michigan	9,835	9,827	1,437	1,437	6.84	0.15
Minnesota	1,397	1,388	281	281	4.94	0.20
Mississippi	1,399	1,394	126	125	11.15	0.09
Missouri	3,328	3,234	498	498	6.49	0.15
Montana	774	772	76	76	10.16	0.10
Nebraska*	819	692	117	117	5.91	0.17
Nevada	993	991	138	138	7.18	0.14
New Hampshire	674	674	140	140	4.81	0.21
New Jersey	7,228	7,173	1,086	1,086	6.60	0.15
New Mexico*	1,210	938	160	160	5.86	0.17
New York	23,287	23,263	3,517	3,517	6.61	0.15
North Carolina	2,737	2,711	255	255	10.63	0.09
North Dakota	296	293	32	32	9.16	0.11
Ohio	8,073	8,058	1,073	1,073	7.51	0.13
Oklahoma	1,241	1,225	314	314	3.90	0.26
Oregon	1,136	1,134	242	242	4.69	0.21
Pennsylvania*	15,670	10,822	2,083	2,083	5.20	0.19
Rhode Island	776	775	113	113	6.86	0.15
South Carolina*	1,347	1,092	121	117	9.33	0.11
South Dakota	274	273	54	54	5.06	0.20
Tennessee	2,132	2,119	293	293	7.23	0.14
Texas	12,649	12,621	1,810	1,810	6.97	0.14
Utah	1,274	1,272	450	450	2.83	0.35
Vermont	359	359	72	72	4.99	0.20
Virginia	2,593	2,584	465	465	5.56	0.18
Washington	2,970	2,963	844	844	3.51	0.28
West Virginia	1,820	1,817	137	137	13.26	0.08
Wisconsin*	1,437	1,215	416	416	2.92	0.34
Wyoming	328	327	34	34	9.62	0.10
Total**	**181,073**	**172,137**	**31,475**	**31,425**	**5.48**	**0.18**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

*Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. Two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice insurer. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide the approximate number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

**"Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals also include reports with no specified State.

Table 7: Number of Medical Malpractice Payment Reports by State, Last Five Years - Physicians
National Practitioner Data Bank (January 1, 1998 - December 31, 2002)

State	1998		1999		2000		2001		2002	
	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*
Alabama	69	68	45	41	83	82	75	75	78	76
Alaska	15	15	20	20	17	17	20	20	20	20
Arizona	222	219	221	221	265	263	298	296	275	272
Arkansas	78	78	69	68	69	69	83	82	95	94
California	1,486	1,484	1,492	1,489	1,397	1,397	1,459	1,457	1,383	1,379
Colorado	152	148	147	147	145	144	136	134	179	179
Connecticut	145	145	155	155	167	167	172	170	178	178
Delaware	30	29	24	23	31	30	52	52	56	51
District of Columbia	82	82	55	55	62	62	76	76	62	60
Florida*	1,047	1,043	1,051	1,047	1,228	1,225	1,302	1,293	1,271	1,265
Georgia	283	282	269	266	275	274	272	272	283	282
Hawaii	45	45	41	41	40	40	41	41	35	35
Idaho	26	26	34	34	33	33	30	30	29	28
Illinois	560	559	550	549	590	589	528	527	491	489
Indiana*	260	155	288	179	286	168	323	217	157	156
Iowa	109	109	73	72	121	121	145	144	134	134
Kansas*	151	92	183	122	188	123	162	112	158	108
Kentucky	127	125	153	153	187	186	186	185	265	263
Louisiana*	283	202	312	189	294	188	305	208	320	200
Maine	34	34	47	47	65	65	39	39	37	37
Maryland	254	254	238	237	249	249	282	282	297	297
Massachusetts	224	224	253	252	324	323	340	338	229	229
Michigan	735	734	750	750	665	663	799	798	761	759
Minnesota	75	75	84	84	87	86	109	109	104	101
Mississippi	116	116	112	112	116	116	144	143	159	159
Missouri	211	200	284	280	200	196	297	287	259	257
Montana	55	55	93	93	67	67	69	69	64	64
Nebraska*	58	51	53	49	78	59	94	75	102	83
Nevada	82	82	83	83	117	117	90	89	123	123
New Hampshire	57	57	42	42	64	64	59	59	42	42
New Jersey	570	567	480	479	617	609	949	939	691	679
New Mexico*	130	90	105	73	108	89	110	89	69	69
New York	1,951	1,950	2,030	2,030	2,105	2,103	2,084	2,081	1,841	1,836
North Carolina	225	223	197	189	216	215	224	224	270	267
North Dakota	23	21	22	22	16	16	23	23	29	29
Ohio	416	415	876	874	846	846	675	675	537	534
Oklahoma	81	81	76	73	104	103	137	136	125	125
Oregon	74	74	85	85	81	81	87	87	111	110
Pennsylvania*	1,148	744	1,435	975	1,403	875	1,566	1,047	1,340	832
Rhode Island	69	69	67	67	67	67	59	59	55	55
South Carolina*	139	116	142	110	160	124	187	131	162	121
South Dakota	27	27	15	15	26	26	23	23	23	23
Tennessee	150	147	189	188	180	179	203	203	211	211
Texas	972	971	1,020	1,017	1,117	1,115	1,172	1,170	1,091	1,089
Utah	86	86	113	113	105	105	108	107	117	117
Vermont	49	49	33	33	23	23	24	24	19	19
Virginia	247	246	230	230	200	199	217	215	221	218
Washington	268	267	325	325	211	211	254	254	244	243
West Virginia	144	144	131	131	169	169	206	206	178	178
Wisconsin*	79	63	72	57	75	70	106	99	121	109
Wyoming	30	30	30	30	26	26	27	27	35	35
Total**	**14,079**	**13,298**	**15,103**	**14,225**	**15,564**	**14,632**	**16,669**	**15,738**	**15,304**	**14,487**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

*Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

**"Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports which did not specify States were excluded.

Table 8: Number of Medical Malpractice Payment Reports by State, Last Five Years - Dentists
National Practitioner Data Bank (January 1, 1998 - December 31, 2002)

State	1998		1999		2000		2001		2002	
	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*
Alabama	10	10	18	18	12	12	14	14	12	12
Alaska	5	5	3	2	7	7	7	7	2	2
Arizona	27	27	36	36	27	27	32	32	33	33
Arkansas	14	14	8	8	11	11	13	13	12	12
California	525	525	438	438	425	425	386	386	454	454
Colorado	18	18	34	34	21	21	24	24	24	24
Connecticut	33	33	26	26	36	36	20	20	21	21
Delaware	5	5	2	2	2	2	5	5	3	3
District of Columbia	11	11	8	8	8	8	8	8	4	4
Florida*	118	118	116	116	118	118	128	128	112	112
Georgia	34	34	151	151	93	93	34	34	57	57
Hawaii	10	10	13	13	15	15	7	7	3	3
Idaho	7	7	4	4	2	2	2	2	4	4
Illinois	77	77	101	101	68	68	79	79	84	84
Indiana*	28	27	22	19	12	11	15	15	14	14
Iowa	12	12	12	12	7	7	13	13	17	17
Kansas*	13	13	17	17	8	8	14	14	9	9
Kentucky	27	27	16	16	13	13	24	24	21	21
Louisiana*	35	34	25	23	21	18	24	19	18	17
Maine	9	9	7	7	8	8	5	5	7	7
Maryland	40	40	40	40	66	66	56	56	52	52
Massachusetts	58	58	89	89	92	92	42	42	60	60
Michigan	81	81	114	114	71	71	79	79	61	61
Minnesota	12	12	11	11	19	19	14	14	10	10
Mississippi	23	23	4	4	11	10	10	10	12	12
Missouri	51	51	44	44	23	23	30	30	21	21
Montana	3	3	5	5	3	3	4	4	7	7
Nebraska*	1	1	4	4	6	6	8	8	6	6
Nevada	5	5	10	10	8	8	17	17	26	26
New Hampshire	8	8	3	3	5	5	8	8	7	7
New Jersey	69	69	63	63	46	46	126	126	76	76
New Mexico*	12	12	9	9	13	13	19	19	16	16
New York	237	237	226	226	388	388	473	473	256	256
North Carolina	16	16	20	20	11	11	18	18	19	19
North Dakota	2	2	3	3	5	5	1	1	7	7
Ohio	75	75	77	77	85	85	53	53	56	56
Oklahoma	17	17	18	18	70	70	34	34	30	30
Oregon	15	15	11	11	44	44	25	25	14	14
Pennsylvania*	145	145	124	124	163	163	149	149	122	122
Rhode Island	4	4	12	12	7	7	8	8	4	4
South Carolina*	4	4	18	18	12	11	10	10	15	12
South Dakota	1	1	5	5	5	5	1	1	3	3
Tennessee	24	24	24	24	26	26	23	23	26	26
Texas	250	250	91	91	93	93	99	99	115	115
Utah	14	14	16	16	13	13	6	6	33	33
Vermont	3	3	2	2	7	7	4	4	8	8
Virginia	54	54	85	85	37	37	29	29	22	22
Washington	62	62	114	114	56	56	56	56	51	51
West Virginia	11	11	10	10	10	10	16	16	7	7
Wisconsin*	24	24	27	27	25	25	33	33	16	16
Wyoming	2	2	2	2	2	2	3	3	11	11
Total**	**2,348**	**2,346**	**2,351**	**2,345**	**2,351**	**2,345**	**2,316**	**2,311**	**2,087**	**2,083**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

*Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

**"Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports which did not specify States were excluded.

Table 9: Mean and Median Medical Malpractice Payment and Mean and Median Delay Between Incident and Payment by State, 2002 and Cumulative - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	2002 Only		Cumulative			2002 Only		Cumulative	
	Mean Payment	Median Payment	Mean Payment	Median Payment	Rank of Cumulative Median Payment**	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)
Alabama	$ 418,366	$ 200,000	$ 348,718	$ 150,000	5	4.36	3.75	4.31	3.96
Alaska	$ 251,832	$ 165,000	$ 227,794	$ 85,000	33	3.46	3.02	3.84	3.53
Arizona	$ 306,232	$ 169,240	$ 223,603	$ 100,000	20	3.53	3.45	3.84	3.33
Arkansas	$ 263,041	$ 125,000	$ 172,633	$ 95,000	28	3.66	3.29	3.43	3.04
California	$ 177,654	$ 67,500	$ 130,627	$ 45,000	51	2.95	2.50	3.35	2.80
Colorado	$ 264,507	$ 100,000	$ 179,931	$ 62,584	47	3.56	3.09	3.35	2.96
Connecticut	$ 508,545	$ 250,000	$ 357,044	$ 150,000	5	5.35	5.10	5.45	5.34
Delaware	$ 521,541	$ 150,000	$ 258,696	$ 100,000	20	4.65	4.56	4.50	4.07
District of Columbia	$ 248,999	$ 162,500	$ 409,858	$ 185,000	2	4.33	4.34	4.79	4.07
Florida*	$ 245,114	$ 162,500	$ 222,391	$ 135,000	8	3.68	3.46	3.99	3.43
Georgia	$ 410,960	$ 175,000	$ 294,614	$ 135,000	8	3.80	3.49	3.63	3.24
Hawaii	$ 373,976	$ 250,000	$ 250,133	$ 95,000	28	3.82	4.25	4.10	3.81
Idaho	$ 238,068	$ 100,000	$ 205,538	$ 52,363	49	3.61	3.23	3.41	3.02
Illinois	$ 543,070	$ 320,000	$ 325,261	$ 199,155	1	5.08	4.86	5.74	5.17
Indiana*	$ 78,861	$ 50,000	$ 153,082	$ 75,001	36	5.70	5.22	5.47	5.07
Iowa	$ 209,232	$ 102,500	$ 174,693	$ 75,000	37	3.42	3.30	3.23	3.05
Kansas*	$ 133,883	$ 103,765	$ 159,693	$ 103,055	19	3.96	3.33	4.01	3.30
Kentucky	$ 185,069	$ 49,000	$ 181,802	$ 70,000	43	4.11	3.16	4.10	3.44
Louisiana*	$ 145,841	$ 100,000	$ 140,908	$ 90,000	30	5.84	5.45	5.04	4.53
Maine	$ 430,999	$ 250,000	$ 258,187	$ 149,000	7	3.83	3.83	4.07	3.71
Maryland	$ 289,238	$ 180,000	$ 249,564	$ 126,000	13	4.42	3.86	4.68	4.22
Massachusetts	$ 457,122	$ 250,000	$ 308,568	$ 175,000	3	6.01	5.73	5.92	5.58
Michigan	$ 121,332	$ 77,000	$ 103,595	$ 70,000	43	4.27	3.84	4.32	3.59
Minnesota	$ 232,518	$ 125,000	$ 189,962	$ 75,000	37	3.23	3.04	3.17	2.79
Mississippi	$ 249,049	$ 131,500	$ 204,362	$ 100,000	20	4.03	3.39	4.11	3.42
Missouri	$ 238,874	$ 162,500	$ 215,989	$ 100,000	20	4.14	3.59	4.48	3.85
Montana	$ 205,696	$ 100,000	$ 156,766	$ 62,500	48	3.71	3.57	4.28	3.81
Nebraska*	$ 171,058	$ 131,250	$ 131,833	$ 75,000	37	4.19	3.89	3.91	3.44
Nevada	$ 317,027	$ 175,000	$ 262,801	$ 105,000	17	4.69	4.55	4.40	4.10
New Hampshire	$ 398,690	$ 250,000	$ 257,418	$ 135,000	8	4.71	3.98	4.80	4.20
New Jersey	$ 350,780	$ 210,000	$ 263,261	$ 125,000	14	5.89	5.11	6.14	5.09
New Mexico*	$ 159,388	$ 110,000	$ 140,538	$ 100,000	20	3.10	3.02	3.81	3.36
New York	$ 348,078	$ 200,000	$ 270,277	$ 131,250	12	6.21	5.54	6.92	6.03
North Carolina	$ 314,937	$ 195,000	$ 253,961	$ 105,000	17	4.25	4.00	3.74	3.37
North Dakota	$ 184,099	$ 75,000	$ 177,570	$ 80,000	34	3.02	2.53	3.43	3.18
Ohio	$ 280,714	$ 137,500	$ 227,049	$ 100,000	20	4.06	3.52	4.47	3.56
Oklahoma	$ 275,142	$ 97,000	$ 243,823	$ 75,000	37	3.89	3.38	3.82	3.19
Oregon	$ 308,814	$ 95,000	$ 199,872	$ 80,000	34	3.47	3.22	3.43	3.01
Pennsylvania*	$ 300,566	$ 200,000	$ 225,105	$ 175,000	3	5.97	5.36	5.96	5.55
Rhode Island	$ 248,801	$ 125,000	$ 264,404	$ 120,000	15	6.42	5.96	6.16	5.85
South Carolina*	$ 252,193	$ 100,000	$ 183,634	$ 100,000	20	4.00	3.90	4.59	4.10
South Dakota	$ 148,120	$ 150,000	$ 203,990	$ 68,518	46	3.69	2.87	3.49	3.12
Tennessee	$ 231,991	$ 110,000	$ 219,996	$ 90,000	30	4.15	3.68	3.71	3.22
Texas	$ 231,262	$ 150,000	$ 189,126	$ 100,000	20	3.77	3.41	3.87	3.43
Utah	$ 195,903	$ 115,000	$ 159,964	$ 50,000	50	3.91	3.61	3.56	3.30
Vermont	$ 109,353	$ 40,865	$ 144,905	$ 70,000	43	3.34	3.03	4.35	4.16
Virginia	$ 298,828	$ 200,000	$ 201,819	$ 115,000	16	4.04	3.53	3.80	3.24
Washington	$ 318,606	$ 150,000	$ 208,461	$ 75,000	37	3.76	3.49	4.31	3.67
West Virginia	$ 229,771	$ 140,465	$ 211,548	$ 90,000	30	4.08	3.88	5.40	4.18
Wisconsin*	$ 448,752	$ 256,357	$ 332,693	$ 132,500	11	4.73	4.32	4.81	4.18
Wyoming	$ 208,387	$ 125,000	$ 166,650	$ 75,000	37	3.04	3.07	3.18	2.98
Total* **	**$ 275,094**	**$ 150,000**	**$ 214,309**	**$ 100,000**		**4.54**	**4.00**	**4.79**	**4.02**

These data are not adjusted for payments by State compensation funds and other similar funds. Mean and median payments for States with payments made by these funds understate the actual mean and median amounts received by claimants. Payments made by these funds may also affect mean and median delay times between incidents and payments. States with these funds are marked with an asterisk.

** Rank of cumulative median payment amounts as of December 31, 2002 is based on the cumulative median payment amount for each State. One is the highest amount; 51 is lowest amount.

*** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports which did not specify States were excluded.

Table 10: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2002 and Cumulative - Physicians National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

	2002 Only			Cumulative				
				Actual			Inflation-Adjusted	
Malpractice Reason	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	467	$ 338,190	$ 150,000	5,691	$ 245,935	$ 93,750	$ 281,049	$ 101,636
Diagnosis Related	5,611	$ 307,418	$ 180,000	61,624	$ 237,867	$ 125,000	$ 267,729	$ 143,794
Equipment / Product Related	36	$ 111,229	$ 45,000	689	$ 71,674	$ 17,500	$ 82,422	$ 20,327
IV & Blood Products Related	53	$ 194,129	$ 75,000	721	$ 168,501	$ 67,500	$ 194,854	$ 75,271
Medication Related	758	$ 184,986	$ 100,000	10,408	$ 157,945	$ 52,500	$ 180,760	$ 63,523
Monitoring Related	157	$ 290,661	$ 162,500	2,090	$ 216,224	$ 90,000	$ 245,988	$ 104,965
Obstetrics Related	1,129	$ 497,121	$ 265,000	15,516	$ 369,543	$ 200,000	$ 420,577	$ 223,447
Surgery Related	4,132	$ 222,285	$ 115,000	49,429	$ 172,172	$ 82,500	$ 194,720	$ 95,398
Treatment Related	2,795	$ 224,837	$ 100,000	32,070	$ 185,687	$ 80,000	$ 210,356	$ 94,879
Miscellaneous	166	$ 113,734	$ 30,500	2,715	$ 95,930	$ 25,000	$ 112,113	$ 29,593
Total	**15,304**	**$ 275,094**	**$ 150,000**	**180,953**	**$ 214,333**	**$ 100,000**	**$ 242,559**	**$ 112,374**

This table includes only disclosable reports in the NPDB as of December 31, 2002. Medical malpractice payment reports that are missing data necessary to calculate payment or malpractice reason are excluded.

Table 11: Mean and Median Delay Between Incident and Payment by Malpractice Reason, 2002 and Cumulative - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

	2002 Only			Cumulative		
Malpractice Reason	Number of Payments	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)	Number of Payments	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)
Anesthesia Related	467	3.74	3.44	5,662	3.71	3.21
Diagnosis Related	5,592	4.75	4.26	61,314	4.82	4.22
Equipment / Product Related	36	3.88	2.92	682	6.58	3.84
IV & Blood Products Related	53	4.24	3.30	718	5.43	4.25
Medication Related	754	4.06	3.65	10,316	5.30	3.78
Monitoring Related	157	4.20	3.81	2,080	5.12	4.14
Obstetrics Related	1,126	5.56	4.63	15,437	6.23	4.94
Surgery Related	4,124	4.20	3.65	49,229	4.28	3.70
Treatment Related	2,785	4.55	3.96	31,909	4.74	4.00
Miscellaneous	166	4.20	3.42	2,679	4.88	3.70
Total	**15,260**	**4.54**	**4.00**	**180,026**	**4.79**	**4.02**

This table includes only disclosable reports in the NPDB as of December 31, 2002. Medical malpractice payment reports which are missing data necessary to calculate payment delay or malpractice reason are excluded.

Table 12: Number of Medical Malpractice Payment Reports by Malpractice Reason - Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Nurse Practitioners/Clinical Nurse Specialists) National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Malpractice Reason	RN (Professional) Nurse	Nurse Anesthetist	Nurse Midwife	Nurse Practitioner	Advanced Nurse Practitioner	Total
Anesthesia Related	100	750	0	5	1	856
Diagnosis Related	166	12	28	114	0	320
Equipment / Product Related	41	4	0	1	0	46
IV & Blood Products Related	132	13	0	2	0	147
Medication Related	426	24	2	31	0	483
Monitoring Related	523	6	8	9	0	546
Obstetrics Related	264	8	281	15	0	568
Surgery Related	274	46	7	5	1	333
Treatment Related	512	23	22	53	2	612
Miscellaneous	151	5	1	7	0	164
Total	**2,589**	**891**	**349**	**242**	**4**	**4,075**

This table includes only disclosable reports in the NPDB as of December 31, 2002. Medical malpractice payment reports which are missing data necessary to determine the malpractice reason are excluded.

Table 13: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2002 and Cumulative - Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Nurse Practitioners/Clinical Nurse Specialists)
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

	2002 Only			Cumulative				
				Actual			Inflation-Adjusted	
Malpractice Reason	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	74	$ 251,991	$ 119,746	856	$ 232,935	$ 100,000	$ 268,557	$ 101,636
Diagnosis Related	48	$ 258,417	$ 112,500	320	$ 306,910	$ 125,000	$ 347,444	$ 139,508
Equipment / Product Related	6	$ 63,583	$ 35,750	46	$ 184,472	$ 38,250	$ 219,691	$ 39,690
IV & Blood Products Related	19	$ 96,570	$ 100,000	147	$ 201,836	$ 67,500	$ 233,135	$ 75,000
Medication Related	56	$ 284,561	$ 79,500	483	$ 245,750	$ 50,000	$ 275,251	$ 59,401
Monitoring Related	41	$ 402,233	$ 150,000	546	$ 304,142	$ 94,100	$ 340,972	$ 101,636
Obstetrics Related	88	$ 554,192	$ 300,000	568	$ 494,292	$ 200,000	$ 540,384	$ 228,682
Surgery Related	35	$ 81,939	$ 50,000	333	$ 157,466	$ 40,000	$ 176,270	$ 45,109
Treatment Related	69	$ 275,325	$ 100,000	612	$ 152,818	$ 50,000	$ 169,096	$ 57,170
Miscellaneous	24	$ 277,908	$ 125,500	164	$ 169,808	$ 38,750	$ 191,270	$ 45,561
Total	**460**	**$ 310,867**	**$ 122,500**	**4,075**	**$ 263,825**	**$ 75,075**	**$ 295,718**	**$ 91,475**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

Table 14: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Malpractice Payment Reports by State - Physicians and Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Nurse Practitioners/Clinical Nurse Specialists) National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	Number of Nurse Reports	Adjusted Number of Nurse Reports*	Adjusted Number of Physician Reports*	Ratio of Adjusted Physician Reports to Adjusted Nurse Reports	Ratio of Adjusted Nurse Reports to Adjusted Physician Reports
Alabama	54	54	743	13.76	0.07
Alaska	12	12	226	18.83	0.05
Arizona	61	61	2,770	45.41	0.02
Arkansas	30	30	853	28.43	0.04
California	161	161	19,207	119.30	0.01
Colorado	66	66	1,914	29.00	0.03
Connecticut	27	27	1,810	67.04	0.01
Delaware	6	6	433	72.17	0.01
District of Columbia	27	27	712	26.37	0.04
Florida*	310	310	12,154	39.21	0.03
Georgia	118	118	3,035	25.72	0.04
Hawaii	8	8	415	51.88	0.02
Idaho	27	27	365	13.52	0.07
Illinois	158	158	7,650	48.42	0.02
Indiana*	22	18	2,380	132.22	0.01
Iowa	20	20	1,440	72.00	0.01
Kansas*	67	47	1,361	28.96	0.03
Kentucky	51	51	1,915	37.55	0.03
Louisiana*	137	118	2,302	19.51	0.05
Maine	11	11	489	44.45	0.02
Maryland	72	72	2,849	39.57	0.03
Massachusetts	238	238	3,274	13.76	0.07
Michigan	98	98	9,827	100.28	0.01
Minnesota	25	25	1,388	55.52	0.02
Mississippi	46	46	1,394	30.30	0.03
Missouri	171	171	3,234	18.91	0.05
Montana	9	9	772	85.78	0.01
Nebraska*	38	37	692	18.70	0.05
Nevada	23	23	991	43.09	0.02
New Hampshire	31	31	674	21.74	0.05
New Jersey	507	507	7,173	14.15	0.07
New Mexico*	67	66	938	14.21	0.07
New York	222	222	23,263	104.79	0.01
North Carolina	68	68	2,711	39.87	0.03
North Dakota	6	6	293	48.83	0.02
Ohio	131	131	8,058	61.51	0.02
Oklahoma	56	56	1,225	21.88	0.05
Oregon	31	31	1,134	36.58	0.03
Pennsylvania*	128	114	10,822	94.93	0.01
Rhode Island	10	10	775	77.50	0.01
South Carolina*	22	20	1,092	54.60	0.02
South Dakota	12	12	273	22.75	0.04
Tennessee	102	102	2,119	20.77	0.05
Texas	369	369	12,621	34.20	0.03
Utah	18	18	1,272	70.67	0.01
Vermont	4	4	359	89.75	0.01
Virginia	62	62	2,584	41.68	0.02
Washington	61	61	2,963	48.57	0.02
West Virginia	30	30	1,817	60.57	0.02
Wisconsin*	34	32	1,215	37.97	0.03
Wyoming	8	8	327	40.88	0.02
Total**	**4,083**	**4,020**	**172,137**	**42.82**	**0.02**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

*Adjusted columns exclude reports from State patient compensation funds and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. Two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide an approximate number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 15: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2002 and Cumulative - Physician Assistants National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

	2002 Only			Cumulative				
				Actual			Inflation-Adjusted	
Malpractice Reason	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	1	$ 415,000	$ 415,000	3	$ 140,963	$ 6,000	$ 141,219	$ 6,298
Diagnosis Related	85	$ 187,909	$ 100,000	370	$ 154,759	$ 80,000	$ 166,072	$ 91,981
Medication Related	8	$ 366,108	$ 79,930	53	$ 105,550	$ 25,000	$ 112,636	$ 29,593
Monitoring Related	0	$ -	$ -	7	$ 129,627	$ 55,000	$ 145,194	$ 67,081
Obstetrics Related	1	$ 125,000	$ 125,000	2	$ 437,500	$ 437,500	$ 477,415	$ 477,415
Surgery Related	5	$ 21,100	$ 15,000	31	$ 60,176	$ 25,000	$ 69,716	$ 25,253
Treatment Related	21	$ 54,393	$ 22,500	167	$ 81,156	$ 24,999	$ 89,597	$ 25,000
Miscellaneous	3	$ 126,667	$ 105,000	25	$ 60,140	$ 50,000	$ 63,419	$ 52,482
Total	**124**	**$ 169,910**	**$ 81,250**	**658**	**$ 124,593**	**$ 54,500**	**$ 134,530**	**$ 60,254**

This table includes only disclosable reports in the NPDB as of December 31, 2002. There have been no reports for physician assistants in the "Equipment/Product Related" and "IV & Blood Products Related" categories.

Table 16: Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank by State
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	Number of Hospitals with "Active" NPDB Registrations	Number of "Active" Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Alabama	124	81	65.3%
Alaska	18	11	61.1%
Arizona	77	33	42.9%
Arkansas	96	58	60.4%
California	459	188	41.0%
Colorado	74	42	56.8%
Connecticut	43	17	39.5%
Delaware	10	3	30.0%
District of Columbia	16	5	37.5%
Florida	239	128	53.6%
Georgia	184	88	47.8%
Hawaii	25	15	60.0%
Idaho	45	27	60.0%
Illinois	221	100	45.2%
Indiana	146	76	52.1%
Iowa	120	84	70.0%
Kansas	150	108	72.0%
Kentucky	119	71	59.7%
Louisiana	197	147	74.6%
Maine	42	21	50.0%
Maryland	73	30	41.1%
Massachusetts	112	62	55.4%
Michigan	170	74	43.5%
Minnesota	139	99	71.2%
Mississippi	105	69	65.7%
Missouri	141	72	51.1%
Montana	47	33	70.2%
Nebraska	87	59	67.8%
Nevada	42	28	66.7%
New Hampshire	30	10	33.3%
New Jersey	103	30	29.1%
New Mexico	44	25	56.8%
New York	264	98	37.1%
North Carolina	137	73	53.3%
North Dakota	50	37	74.0%
Ohio	209	91	43.5%
Oklahoma	147	100	68.0%
Oregon	65	24	36.9%
Pennsylvania	263	131	49.8%
Rhode Island	15	4	26.7%
South Carolina	74	40	54.1%
South Dakota	57	45	78.9%
Tennessee	147	90	61.2%
Texas	504	327	64.9%
Utah	47	20	42.6%
Vermont	17	9	52.9%
Virginia	111	55	49.5%
Washington	91	37	40.7%
West Virginia	64	33	51.6%
Wisconsin	138	87	63.0%
Wyoming	24	17	70.8%
Total	**5,963**	**3,240**	**54.3%**

"Currently active" registered hospitals are those listed by the NPDB as being active on December 31, 2002.

Table 17: Clinical Privilege Reports and Ratio of Adverse Clinical Privilege Reports to Adverse In-State Licensure Reports by State - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	Number of Clinical Privilege Reports*	Adverse Clinical Privilege Reports*	Adverse Licensure Reports for In-State Physicians	Ratio of Adverse Clinical Privilege Reports to Adverse In-State Licensure
Alabama	136	124	369	0.34
Alaska	17	16	130	0.12
Arizona	324	296	644	0.46
Arkansas	101	89	199	0.45
California	1,274	1,190	2,909	0.41
Colorado	202	193	915	0.21
Connecticut	71	68	409	0.17
Delaware	25	24	31	0.77
District of Columbia	37	35	94	0.83
Florida	568	522	1,370	0.38
Georgia	338	317	677	0.47
Hawaii	50	45	60	0.75
Idaho	49	42	71	0.59
Illinois	294	276	656	0.42
Indiana	248	225	224	1.00
Iowa	100	92	413	0.22
Kansas	174	164	186	0.88
Kentucky	139	131	518	0.25
Louisiana	147	134	398	0.34
Maine	54	51	166	0.31
Maryland	264	246	846	0.29
Massachusetts	348	314	611	0.51
Michigan	363	337	1,279	0.26
Minnesota	140	133	379	0.35
Mississippi	70	67	399	0.17
Missouri	193	181	589	0.31
Montana	45	39	103	0.38
Nebraska	94	88	84	1.05
Nevada	133	118	119	0.99
New Hampshire	57	53	109	0.49
New Jersey	328	294	992	0.30
New Mexico	62	57	64	0.89
New York	776	717	2,458	0.29
North Carolina	195	177	344	0.51
North Dakota	34	31	134	0.23
Ohio	483	450	1,701	0.26
Oklahoma	179	166	517	0.32
Oregon	129	121	446	0.27
Pennsylvania	401	373	709	0.53
Rhode Island	55	51	118	0.43
South Carolina	129	119	324	0.37
South Dakota	19	18	40	0.45
Tennessee	184	167	311	0.54
Texas	723	671	1,736	0.39
Utah	76	75	151	0.50
Vermont	30	25	105	0.24
Virginia	220	202	1,382	0.15
Washington	260	237	470	0.50
West Virginia	93	82	395	0.21
Wisconsin	183	164	251	0.65
Wyoming	23	22	54	0.41
Total**	**10,926**	**10,102**	**27,671**	**0.37**

This table includes only disclosable reports in the NPDB as of December 31, 2002. Clinical privilege reports are attributed to States on the basis of where the physician worked. Licensure reports are attributed to the State of the board taking the action. "In-State" refers to the State where the physician or dentist was practicing at the time the licensure action was taken.

* "Clinical Privilege Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands) as well as non-adverse actions reported as adverse (e.g restorations and reinstatements). "Adverse Clinical Privilege Reports" include only adverse actions.

** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 18: Cumulative Licensure Actions by State - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	Number of Licensure Actions*	Number of Adverse Licensure Actions*	Percent of Adverse Licensure Actions	Number of Adverse Licensure Actions for In-State Physicians**	Percent of All Adverse Licensure Actions for In-State Physicians
Alabama	456	403	88.4%	369	91.6%
Alaska	139	131	94.2%	130	99.2%
Arizona	1,039	945	91.0%	644	68.1%
Arkansas	232	205	88.4%	199	97.1%
California	3,950	3,461	87.6%	2,909	84.1%
Colorado	1,010	920	91.1%	915	99.5%
Connecticut	444	426	95.9%	409	96.0%
Delaware	45	38	84.4%	31	81.6%
District of Columbia	149	140	88.0%	94	60.6%
Florida	1,746	1,504	86.1%	1,370	91.1%
Georgia	840	752	89.5%	677	90.0%
Hawaii	87	80	92.0%	60	75.0%
Idaho	120	102	85.0%	71	69.6%
Illinois	1,054	822	78.0%	656	79.8%
Indiana	342	291	85.1%	224	77.0%
Iowa	599	530	88.5%	413	77.9%
Kansas	229	191	83.4%	186	97.4%
Kentucky	670	571	85.2%	518	90.7%
Louisiana	542	460	84.9%	398	86.5%
Maine	182	169	92.9%	166	98.2%
Maryland	988	910	92.1%	846	93.0%
Massachusetts	695	664	95.5%	611	92.0%
Michigan	1,572	1,411	89.8%	1,279	90.6%
Minnesota	486	403	82.9%	379	94.0%
Mississippi	463	421	90.9%	399	94.8%
Missouri	733	694	94.7%	589	84.9%
Montana	123	112	91.1%	103	92.0%
Nebraska	93	90	96.8%	84	93.3%
Nevada	140	140	100.0%	119	85.0%
New Hampshire	116	114	98.3%	109	95.6%
New Jersey	1,399	1,216	86.9%	992	81.6%
New Mexico	71	70	98.6%	64	91.4%
New York	3,272	3,255	99.5%	2,458	75.5%
North Carolina	464	383	82.5%	344	89.8%
North Dakota	196	146	74.5%	134	91.8%
Ohio	2,191	1,843	84.1%	1,701	92.3%
Oklahoma	624	543	87.0%	517	95.2%
Oregon	472	453	96.0%	446	98.5%
Pennsylvania	1,155	1,083	93.8%	709	65.5%
Rhode Island	141	131	92.9%	118	90.1%
South Carolina	454	332	73.1%	324	97.6%
South Dakota	47	44	93.6%	40	90.9%
Tennessee	409	349	85.3%	311	89.1%
Texas	2,110	1,840	87.2%	1,736	94.3%
Utah	220	184	83.6%	151	82.1%
Vermont	127	120	94.5%	105	87.5%
Virginia	1,612	1,425	88.4%	1,382	97.0%
Washington	651	524	80.5%	470	89.7%
West Virginia	519	426	82.1%	395	92.7%
Wisconsin	334	289	86.5%	251	86.9%
Wyoming	65	60	92.3%	54	90.0%
Total* **	**35,830**	**31,829**	**88.8%**	**27,671**	**86.9%**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

* "Number of Licensure Actions" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as adverse actions (e.g., restorations and reinstatements). "Number of Adverse Licensure Actions" include only truly adverse actions.

** "In-State" refers to the State where the physician practiced at the time the licensure action was taken.

*** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 19: Cumulative Licensure Actions by State - Dentists
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

State	Number of Licensure Actions*	Number of Adverse Licensure Actions*	Percent of Adverse Licensure Actions	Number of Adverse Licensure Actions for In-State Dentists**	Percent of All Adverse Licensure Actions for In-State Dentists
Alabama	99	98	99.0%	95	96.9%
Alaska	46	44	95.7%	44	100.0%
Arizona	622	620	99.7%	620	100.0%
Arkansas	31	28	90.3%	28	100.0%
California	422	418	99.1%	413	98.8%
Colorado	487	484	99.4%	475	98.1%
Connecticut	140	132	94.3%	130	98.5%
Delaware	2	2	100.0%	2	100.0%
District of Columbia	1	1	100.0%	1	100.0%
Florida	429	393	91.6%	389	99.0%
Georgia	165	165	100.0%	162	98.2%
Hawaii	7	7	100.0%	7	100.0%
Idaho	17	17	100.0%	16	94.1%
Illinois	434	309	71.2%	290	93.9%
Indiana	68	56	82.4%	50	89.3%
Iowa	169	162	95.9%	140	86.4%
Kansas	32	32	100.0%	30	93.8%
Kentucky	85	84	98.8%	84	100.0%
Louisiana	129	125	96.9%	125	100.0%
Maine	41	41	100.0%	40	97.6%
Maryland	210	170	81.0%	162	95.3%
Massachusetts	157	149	94.9%	140	94.0%
Michigan	476	430	90.3%	408	94.9%
Minnesota	189	146	77.2%	146	100.0%
Mississippi	57	56	98.2%	55	98.2%
Missouri	130	128	98.5%	121	94.5%
Montana	19	19	100.0%	18	94.7%
Nebraska	42	39	92.9%	37	94.9%
Nevada	30	29	96.7%	28	96.6%
New Hampshire	25	25	100.0%	25	100.0%
New Jersey	276	254	92.0%	252	99.2%
New Mexico	12	11	91.7%	11	100.0%
New York	457	454	99.3%	453	99.8%
North Carolina	264	258	97.7%	258	100.0%
North Dakota	2	2	100.0%	1	50.0%
Ohio	657	632	96.2%	632	100.0%
Oklahoma	93	92	98.9%	89	96.7%
Oregon	285	284	99.6%	279	98.2%
Pennsylvania	187	182	97.3%	150	82.4%
Rhode Island	15	15	100.0%	14	93.3%
South Carolina	76	75	98.7%	75	100.0%
South Dakota	3	3	100.0%	3	100.0%
Tennessee	152	139	91.4%	138	99.3%
Texas	361	357	98.9%	356	99.7%
Utah	87	69	79.3%	61	88.4%
Vermont	6	5	83.3%	5	100.0%
Virginia	698	661	94.7%	661	100.0%
Washington	231	218	94.4%	205	94.0%
West Virginia	15	15	100.0%	15	100.0%
Wisconsin	158	143	90.5%	141	98.6%
Wyoming	4	4	100.0%	4	100.0%
Total* **	**8,803**	**8,285**	**94.1%**	**8,087**	**97.6%**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

* "Number of Licensure Actions" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands) as well as non-adverse actions reported as adverse actions (e.g., restorations and reinstatements). "Number of Adverse Licensure Actions" include only truly adverse actions.

** "In-State" refers to the State where the dentist practiced at the time the licensure action was taken.

*** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 20: Relationship Between Frequency of Medical Malpractice Payment Reports, Adverse Action Reports, and Medicare/Medicaid Exclusion Reports - Physicians National Practitioner Data Bank (September 1, 1990 - December 31, 2002)**

Number of Medical Malpractice Payment Reports	Number of Physicians with Specified Number of Malpractice Payment Reports	Number of Physicians with Specified Number of Medical Malpractice Payment Reports Also Having One or More Adverse Action Reports***		Number of Physicians with Specified Number of Medical Malpractice Payment Reports Also Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	81,492	4,251	5.2%	601	0.7%
2	22,670	1,755	7.7%	234	1.0%
3	7,304	777	10.6%	120	1.6%
4	2,930	448	15.3%	47	1.6%
5	1,242	211	17.0%	37	3.0%
6	656	129	19.7%	25	3.8%
7	333	85	25.5%	12	3.6%
8	181	44	24.3%	8	4.4%
9	131	42	32.1%	5	3.8%
10 or More	333	138	41.4%	29	8.7%
Total	**117,272**	**7,880**	**6.7%**	**1,118**	**1.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2002.

* "Adverse Action Reports" include those reports as defined in footnote 1 on page 5 of this Annual Report, except that in this table Exclusion actions are reported separately.

*** For example, 81,492 physicians have one medical malpractice payment report in the NPDB; of these physicians, 4,251 have one or more adverse action reports (5.2%) and 77,241 (94.8%) have no adverse action reports. Similarly, of the 81,492 physicians with one medical malpractice payment report, 601 (0.7%) have one exclusion report and 86,871 (99.3%) have no exclusion reports.

Table 21: Relationship Between Frequency of Adverse Action Reports*, Medical Malpractice Payment Reports, and Medicare/Medicaid Exclusion Reports -- Physicians National Practitioner Data Bank (September 1, 1990 - December 31, 2002)**

Number of Adverse Action Reports for Each Physician	Number of Physicians with Specified Number of Adverse Action Reports	Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medical Malpractice Payment Reports		Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	10,685	3,600	33.7%	920	8.6%
2	5,472	1,947	35.6%	780	14.3%
3	2,638	998	37.8%	532	20.2%
4	1,405	566	40.3%	300	21.4%
5	792	296	37.4%	199	25.1%
6	429	184	42.9%	123	28.7%
7	258	123	47.7%	74	28.7%
8	148	70	47.3%	43	29.1%
9	81	34	42.0%	27	33.3%
10 or More	159	62	39.0%	58	36.5%
Total	**22,067**	**7,880**	**35.7%**	**3,056**	**13.8%**

* "Adverse Action Reports" include those reports as defined in footnote 1 on page 5 of this Annual Report, except that in this table Exclusion actions are reported separately.

** This table includes only disclosable reports in the NPDB as of December 31, 2002.

*** For example, 10,685 physicians have one adverse action report in the NPDB; of these physicians, 3,600 have one or more medical malpractice payment reports (33.7%) and 7,085 (66.3%) have no medical malpractice payment reports. Similarly, of the 10,685 physicians with one adverse action report, 920 (8.6%) have one exclusion report and 9,765 (91.4%) have no exclusion reports.

Table 22: Number, Percent, and Percent Change in Queries and Queries Matched, Last Five Years and Cumulative National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Query Type	1998	1999	2000	2001	2002	Cumulative
ENTITY QUERIES*						
Total Entity Queries	3,155,558	3,221,017	3,324,858	3,231,086	3,254,393	28,795,703
Queries Percent Increase/Decrease from Previous Year	0.7%	2.1%	3.2%	-2.8%	0.7%	n/a
Matched Queries	374,002	401,198	419,302	428,440	439,761	3,154,393
Percent Matched	11.9%	12.5%	12.6%	13.3%	13.5%	11.0%
Matches Percent Increase/Decrease from Previous Year	4.1%	7.3%	4.5%	2.2%	2.6%	n/a
SELF-QUERIES						
Total Practitioner Self Queries	48,287	41,410	33,248	36,608	37,804	413,775
Self-Queries Percent Increase/Decrease From Previous Year	-8.2%	-14.2%	-19.7%	10.1%	3.3%	n/a
Matched Self-Queries	4,293	3,441	2,743	3,293	3,763	33,930
Self-Queries Percent Matched	8.9%	8.3%	8.3%	9.0%	10.0%	8.2%
Matches Percent Increase/Decrease from Previous Year	-8.7%	-19.8%	-20.3%	20.1%	14.3%	n/a
TOTAL QUERIES (ENTITY AND SELF	**3,203,845**	**3,262,427**	**3,358,106**	**3,267,694**	**3,292,197**	**29,209,478**
TOTAL MATCHED (ENTITY AND SELF	**378,295**	**404,639**	**422,045**	**431,733**	**443,524**	**3,188,323**
TOTAL PERCENT MATCHED (ENTITY AND SELF	**11.8%**	**12.4%**	**12.6%**	**13.2%**	**13.5%**	**10.9%**

* "ENTITY QUERIES" exclude practitioner self-queries except those submitted electronically by entities using QPRAC in 1999 and 2000.

Table 23: Queries by Type of Querying Entity, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Entity Type*	1998			1999			2000		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers									
Hospitals	5,780	1,081,591	36.3%	5,769	1,095,310	34.0%	5,784	1,117,814	34.0%
Voluntary Queriers									
State Licensing Board	67	12,562	0.4%	68	12,199	0.4%	86	12,475	0.4%
Managed Care Organizations	1,261	1,566,522	52.6%	1,227	1,615,264	50.1%	1,190	1,690,425	51.4%
Professional Societies	91	14,081	0.5%	87	11,570	0.4%	82	9,680	0.3%
Other Health Care Entities	1,982	302,455	10.2%	2,845	488,005	15.1%	3,141	459,688	14.0%
Total Voluntary Queriers	**3,401**	**1,895,620**	**63.7%**	**4,227**	**2,127,038**	**66.0%**	**4,499**	**2,172,268**	**66.0%**
Total**	**9,181**	**2,977,211**	**100.0%**	**9,993**	**3,222,348**	**100.0%**	**10,283**	**3,291,610**	**100.0%**

Entity Type*	2001			2002			Cumulative		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers									
Hospitals	5,763	1,115,067	34.5%	5,810	1,116,844	34.3%	7,683	11,772,004	40.9%
Voluntary Queriers									
State Licensing Board	92	17,491	0.5%	93	18,952	0.6%	167	138,530	0.5%
Managed Care Organizations	1,123	1,627,544	50.4%	1,035	1,626,205	50.0%	1,984	13,072,747	45.4%
Professional Societies	79	8,179	0.3%	78	7,472	0.2%	203	86,012	0.3%
Other Health Care Entities	3,408	462,262	14.3%	3,768	482,814	14.8%	6,338	3,725,082	12.9%
Total Voluntary Queriers	**4,702**	**2,115,476**	**65.5%**	**4,974**	**2,135,443**	**65.6%**	**8,692**	**17,022,371**	**59.1%**
Total**	**10,465**	**3,231,086**	**100.0%**	**10,832**	**3,254,393**	**100.0%**	**16,372**	**28,795,703**	**100.0%**

* "Entity Type" is based on how an entity is currently registered and may be different from previous years. Thus, the number of queriers for each entity type also may vary slightly from previous years.

** "Total" excludes practitioner self-queries except those submitted by entities using QPRAC in 1999 and 2000.

Table 24: Number of Queries by Practitioner Type
National Practitioner Data Bank (October 1, 2002- November 30, 2002)

Practitioner Type	Number of Queries (October 2002-November 2002)	Percent of Total Queries	Number of Matched Queries (October 2002-November 2002)	Percent of Matched Queries
Acupuncturist	290	0.15%	0	0.00
Adult Care Facility Administrator	1	0.00%	0	0.00
Allopathic Physician Intern/Resident	446	0.23%	4	0.01
Allopathic Physician	120,969	62.36%	1,299	0.01
Art/Recreation Therapist	5	0.00%	0	0.00
Athletic Trainer	10	0.01%	0	0.00
Audiologists	338	0.17%	1	0.00
Business Owner	5	0.00%	0	0.00
Chiropractor	6,311	3.25%	71	0.01
Clinical Nurse Specialist	48	0.02%	0	0.00
Cytotechnologist	0	0.00%	0	0.00
Dental Assistant	32	0.02%	0	0.00
Dental Hygienist	44	0.02%	1	0.02
Dental Resident	18	0.01%	0	0.00
Dentist	9,001	4.64%	220	0.02
Denturist	4	0.00%	0	0.00
Dietician	173	0.09%	0	0.00
EMT, Basic	5	0.00%	0	0.00
EMT, Cardiac/Critical Care	1	0.00%	0	0.00
EMT, Intermediate	0	0.00%	0	0.00
EMT, Paramedic	12	0.01%	0	0.00
Home Health Aide (Homemaker)	0	0.00%	0	0.00
Homeopath	0	0.00%	0	0.00
Insurance Broker	0	0.00%	0	0.00
Long Term Care Facility Administrator	12	0.01%	0	0.00
LPN or Vocational Nurse	203	0.10%	0	0.00
Marriage and Family Therapist	656	0.34%	0	0.00
Massage Therapist	386	0.20%	0	0.00
Medical Assistant	29	0.01%	0	0.00
Medical Technologist	22	0.01%	0	0.00
Mental Health Counselor	1,415	0.73%	1	0.00
Midwife, Lay (Non-Nurse)	20	0.01%	0	0.00
Naturopath	46	0.02%	0	0.00
Nuclear Med. Technologist	3	0.00%	0	0.00
Nurse Anesthetist	949	0.49%	11	0.01
Nurse Midwife	531	0.27%	3	0.01
Nurse Practitioner	3,449	1.78%	14	0.00
Nurses Aide	15	0.01%	0	0.00
Nutritionist	23	0.01%	0	0.00
Occupational Therapy Assistant	4	0.00%	0	0.00
Occupational Therapist	589	0.30%	3	0.01
Ocularist	3	0.00%	0	0.00
Optician	47	0.02%	0	0.00
Optometrist	7,233	3.73%	70	0.01
Orthotics/Prosthetics Fitter	11	0.01%	0	0.00
Osteopathic Physician Intern/Resident	55	0.03%	2	0.04
Osteopathic Physician	7,193	3.71%	153	0.02
Other Health Care Practitioner, Not Classified	192	0.10%	3	0.02
Other Non-Practitioner Occupation, Not Classified	222	0.11%	1	0.00
Perfusionist	3	0.00%	0	0.00
Pharmacist	517	0.27%	4	0.01
Pharmacist, Nuclear	3	0.00%	0	0.00
Pharmacy Assistant	40	0.02%	1	0.03
Pharmacy Intern	0	0.00%	0	0.00
Pharmacy Technician	3	0.00%	0	0.00
Phys. Asst., Allopathic	2,721	1.40%	21	0.01
Phys. Asst., Osteopathic	67	0.03%	0	0.00
Phys. Therapy Assistant	32	0.02%	0	0.00
Physical Therapist	3,309	1.71%	12	0.00
Podiatric Assistant	56	0.03%	0	0.00
Podiatrist	2,975	1.53%	34	0.01
Professional Counselor, Substance Abuse	117	0.06%	0	0.00
Professional Counselor, Alcohol	114	0.06%	0	0.00
Professional Counselor, Family/Marriage	873	0.45%	2	0.00
Professional Counselor	2,195	1.13%	6	0.00
Psychiatric Technicians	21	0.01%	0	0.00
Psychological Assistant, Associate, Examiner	20	0.01%	0	0.00
Psychologist	4,878	2.51%	20	0.00
Rad. Therapy Technologist	4	0.00%	0	0.00
Radiologic Technologists	24	0.01%	0	0.00
Rehabilitation Therapist	18	0.01%	0	0.00
Researcher, Clinical	0	0.00%	0	0.00
Respiratory Therapy Technician	2	0.00%	0	0.00
Respiratory Therapist	8	0.00%	1	0.13
RN (Professional) Nurses	2,727	1.41%	15	0.01
Salesperson	0	0.00%	0	0.00
School Psychologist	1	0.00%	0	0.00
Social Worker, Clinical	11,787	6.08%	21	0.00
Speech/Language Pathologist	456	0.24%	0	0.00
Total	**193,992**	**100.00%**	**1,994**	**0.01**

Table 25: Entities That Have Queried or Reported to the National Practitioner Data Bank
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Entity Type	Active Status 12/31/2002	Active At Any Time
Hospitals	6,200	7,698
State Licensing Boards	163	205
Managed Care Organizations	1,324	2,025
Professional Societies	121	217
Other Health Care Entities	4,879	6,406
Medical Malpractice Payers	347	739
Total	**13,034**	**17,290**

The counts shown in this table are based on entity registrations. A few entities have registered more than once. Thus, the entity counts shown in this table may be slightly exaggerated. Entities that report both clinical privileges actions and medical malpractice payments (e.g., hospitals and HMOs) are instructed to register as health care entities, not malpractice payers, and are not double counted if they registered only once.

Table 26: Requests for Secretarial Review by Report Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

	1998			1999			2000		
Category	**Number**	**Percent**	**% Change 1997-1998**	**Number**	**Percent**	**% Change 1998-1999**	**Number**	**Percent**	**% Change 1999-2000**
Adverse Actions*	**59**	**54.1%**	**-25.3%**	**78**	**67.8%**	**24.4%**	**73**	**57.9%**	**-6.4%**
State Licensure Actions	21	35.6%	-40.0%	31	39.7%	32.3%	22	30.1%	-29.0%
Clinical Privilege Actions	38	64.4%	-17.4%	46	59.0%	17.4%	39	53.4%	-15.2%
Professional Society Actions	0	0.0%	0.0%	1	1.3%	0.0%	2	2.7%	0.0%
Medicare/Medicaid Exclusions	0	0.0%	0.0%	0	0.0%	0.0%	10	13.7%	0.0%
Medical Malpractice Payments	50	45.9%	16.3%	37	32.2%	-35.1%	53	42.1%	43.2%
Total	**109**	**100.0%**	**-9.2%**	**115**	**100.0%**	**5.2%**	**126**	**100.0%**	**9.6%**

	2001			2002			Cumulative	
Category	**Number**	**Percent**	**% Change 2000-2001**	**Number**	**Percent**	**% Change 2001-2002**	**Number**	**Percent**
Adverse Actions	**58**	**66.7%**	**-20.5%**	**83**	**70.3%**	**43.1%**	**981**	**61.97%**
State Licensure Actions	17	29.3%	-22.7%	17	20.5%	0.0%	306	31.2%
Clinical Privilege Actions	31	53.4%	-20.5%	56	67.5%	80.6%	630	64.2%
Professional Society Actions	1	1.7%	-50.0%	0	0.0%	-100.0%	16	1.6%
Medicare/Medicaid Exclusions	9	15.5%	0.0%	10	12.0%	11.1%	29	3.0%
Medical Malpractice Payments	29	33.3%	-45.3%	35	29.7%	20.7%	602	38.0%
Total	**87**	**100.0%**	**-31.0%**	**118**	**100.0%**	**35.6%**	**1,583**	**100.0%**

* "Adverse Action Reports" include those reports as defined in footnote 1 on page 5 of this Annual Report.

Table 27: Distribution of Requests for Secretarial Review by Type of Outcome, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

	1998			1999			2000		
Outcome	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	2	1.8%	1.8%	12	10.4%	10.7%	11	8.7%	9.5%
Request Closed: Practitioner Did Not Pursue Review*	6	5.5%	5.5%	2	1.7%	1.8%	0	0.0%	0.0%
Request Outside Scope of Review (No Change in Report)	35	32.1%	32.1%	34	29.6%	30.4%	71	56.3%	61.2%
Secretary Changes Report	0	0.0%	0.0%	0	0.0%	0.0%	1	0.8%	0.9%
Secretary Maintains Report as Submitted	61	56.0%	56.0%	55	47.8%	49.1%	31	24.6%	26.7%
Secretary Voids Report	5	4.6%	4.6%	9	7.8%	8.0%	2	1.6%	1.7%
Unresolved as of December 31, 2002	0	0.0%	n/a	3	2.6%	2.7%	10	7.9%	n/a
Total	**109**	**100.0%**	**100.0%**	**115**	**100.0%**	**100.0%**	**126**	**100.0%**	**100.0%**

	2001			2002			Cumulative		
Outcome	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	2	2.3%	3.0%	7	5.9%	12.5%	83	5.2%	5.6%
Request Closed: Practitioner Did Not Pursue Review*	0	0.0%	0.0%	1	0.8%	-0.8%	42	2.7%	2.8%
Request Outside Scope of Review (No Change in Report)	42	48.3%	63.6%	28	23.7%	50.0%	620	39.2%	41.9%
Secretary Changes Report	1	1.1%	1.5%	0	0.0%	0.0%	17	1.1%	1.1%
Secretary Maintains Report as Submitted	20	23.0%	30.3%	17	14.4%	30.4%	581	36.7%	39.3%
Secretary Voids Report	1	1.1%	1.5%	3	2.5%	5.4%	137	8.7%	9.3%
Unresolved as of December 31, 2002	21	24.1%	n/a	62	52.5%	n/a	103	6.5%	n/a
Total	**87**	**100.0%**	**100.0%**	**118**	**100.0%**	**100.0%**	**1,583**	**100.0%**	**100.0%**

This table represents the outcomes of Secretarial Review requests based on the date of the requests. For undated requests, the date they were received by the Division of Practitioner Data Banks was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to requests for Secretarial Review that were closed because of practitioner actions (written statements) or inactions (failing to submit supporting documentation) that terminated the Secretarial Review process.

Table 28: Cumulative Resolved Requests for Secretarial Review by Report Type and Outcome Type
National Practitioner Data Bank (September 1, 1990 - December 31, 2002)

Outcome	Malpractice Payments		Licensure Actions		Clinical Privileges Actions	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Request Closed by Intervening Action	27	4.5%	22	7.2%	32	5.1%
Request Closed: Practitioner Did Not Pursue Review*	16	2.7%	11	3.6%	14	2.2%
Request Outside Scope of Review (No Change in Report)	337	56.0%	72	23.5%	190	30.2%
Secretary Changes Report	6	1.0%	8	2.6%	3	0.5%
Secretary Maintains Report as Submitted	162	26.9%	138	45.1%	273	43.3%
Secretary Voids Report	30	5.0%	38	12.4%	66	10.5%
Unresolved as of December 31, 2002	24	4.0%	17	5.6%	52	8.3%
Total	**602**	**100.0%**	**306**	**100.0%**	**630**	**100.0%**

Outcome	Professional Society Actions		Medicare/Medicaid Exclusions		Total	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Request Closed by Intervening Action	2	12.5%	0	0.0%	83	5.24%
Request Closed: Practitioner Did Not Pursue Review*	1	6.3%	0	0.0%	42	2.65%
Request Outside Scope of Review (No Change in Report)	5	31.3%	16	55.2%	620	39.17%
Secretary Changes Report	0	0.0%	0	0.0%	17	1.07%
Secretary Maintains Report as Submitted	5	31.3%	3	10.3%	581	36.70%
Secretary Voids Report	3	18.8%	0	0.0%	137	8.65%
Unresolved as of December 31, 2002	0	0.0%	10	34.5%	103	6.51%
Total	**16**	**100.0%**	**29**	**100.0%**	**1,583**	**100.0%**

This table represents the outcomes of Secretarial Review requests based on the date of the requests. For undated requests, the date they were received by the Division of Practitioner Data Banks was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to requests for Secretarial Review which were closed because of practitioner actions (written statements) or inactions (failing to submit supporting documentation) that terminated the Secretarial Review process.